Supreme Court, U.S.
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In the Supreme Court of the United States

OCTOBER TERM, 1994

NATIONAL UNION FIRE INSURANCE COMPANY,
Petitioner,

VS.

CNA INSURANCE COMPANIES AND
COLUMBIA CASUALTY COMPANY,
Respondents.

ON PETITION FOR WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED FOR REVIEW

I. Whether the Court of Appeals erroneously construed Texas substantive law in affirming the grant of summary judgment for the insurer by finding that a self-insured retention with limited rights to approve settlements transforms an insured into a primary carrier and destroys the duties owed to the insured by the insurer.

II. Whether the Court of Appeals erroneously construed Texas substantive law in affirming the grant of Columbia's summary judgment and the denial of National Union's partial summary judgment in holding that the insured exercised the exclusive control over the defense and negotiations, and that under the policy, the insurer owed no duty to the insured to negotiate or settle the claim.

III. Whether the Court of Appeals erroneously construed Texas substantive law in affirming the grant of summary judgment by ruling that the insurer's actual documented role in the handling of the claim, including the exclusive handling of settlement negotiations, as a matter of law, did not create a duty of reasonable care to the insured regardless of the policy provisions.

IV. Whether the Court of Appeals erroneously construed Texas substantive law in affirming the grant of summary judgment on an insurer's duties to the insured by ruling that Texas law imposes no duty on an insurer to attempt to settle

QUESTIONS PRESENTED FOR REVIEW (continued)

within policy limits and that the insurer is not answerable to the insured if it does not.

V. Whether the Court of Appeals erroneously construed Texas substantive law in affirming the lower court's ruling that the excess carrier could not be entitled to contractual subrogation.

VI. Whether the Court of Appeals erroneously construed Texas substantive law in holding that Texas statutory duties imposed under the Texas Deceptive Trade Practices Act can be contractually waived in policy provisions and are mooted by the court's contractual and tort analysis.

PARTIES TO THE PROCEEDING

In accordance with Rules 14(b) and 29.1, the list of all parties to this proceeding includes:

National Union Fire Insurance Company, Petitioner

American International Group, Inc., Petitioner's Parent Company

CNA Insurance Companies, Respondent

Columbia Casualty Company, Respondent

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No._____

In the
Supreme Court of the United States
OCTOBER TERM, 1994

NATIONAL UNION FIRE INSURANCE COMPANY,
Petitioner,

VS.

CNA INSURANCE COMPANIES AND
COLUMBIA CASUALTY COMPANY,
Respondents.

PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

TO THE HONORABLE SUPREME COURT OF THE UNITED STATES:

Petitioner, National Union Fire Insurance Company ("National Union"), an excess carrier, sued the primary carrier, Columbia Casualty Company ("Columbia"), in Texas state district court over its negligent handling of an insurance claim. Columbia removed the case to federal court on the basis of diversity of citizenship. The United States District Court for the Eastern District of Texas granted Columbia's motion for summary judgment on July 16, 1993 and denied National Union's Motion for Partial Summary Judgment. The Fifth Circuit Court of Appeals affirmed this decision on August 10, 1994, and denied National Union's Motion for Rehearing on September 4, 1994.

STATEMENT OF JURISDICTION

The Fifth Circuit Court of Appeals affirmed the district court's grant of summary judgment for Columbia on August 10, 1994. National Union's petition for rehearing was denied on September 4, 1994. Under 28 U.S.C. § 1254 (1988), this Court has jurisdiction to review this case by a writ of certiorari.

STATUTES INVOLVED IN THE CASE

28 U.S.C. § 1652 (1988). **State Laws as rules of decision**

> The laws of the several states, except where the Constitution or treaties of the United States or Acts of Congress otherwise require or provide, shall be regarded as rules of decision in civil actions in the courts of the United States, in cases where they apply.

TEX. INS. CODE ANN. art. 1.14 (Vernon 1981). **Shall Issue Certificate of Authority**

> Sec. 2. The word "Carrier" as herein used is defined as that type of insurer which, in consideration of premium, issues policies to others insuring against those losses which may be insured against under the provisions of the law, including stock companies, reciprocals or inter-insurance exchanges, Lloyds' associations, fraternal benefit societies and mutual companies of all kinds, including state-wide assessment associations, local mutual aids, burial associations, and county and farm mutual fire associations. Provided that the

Board of Insurance Commissioners shall give preference to applications of domestic companies in checking and approving annual statements and issuing Certificates of Authority.

TEX. BUS. & COM. CODE ANN. § 17.42 (Vernon Supp. 1994). **Waivers: Public Policy**

(a) Any waiver by a consumer of the provisions of this subchapter is contrary to public policy and is unenforceable and void; provided, however, that a waiver is valid and enforceable if a defendant in an action or claim under this subchapter pleads and proves:

(1) the consumer is not in a significantly disparate bargaining position;

(2) the consumer is represented by legal counsel in seeking or acquiring goods or services, other than the purchase or lease of a family residence occupied or to be occupied as the consumer's residence, by a purchase or a lease for a consideration paid or to be paid that exceeds $500,000; and

(3) the consumer waives all or part of this subchapter, other than Section 17.555, by an express provision in a written contract signed by both the consumer and the consumer's legal counsel; and provided, however, that a business consumer with assets of $5 million or more according to the most recent financial statement of the business consumer prepared in accordance with generally accepted accounting principles that has knowledge and experience in financial and business matters that enable it

> to evaluate the merits and risks of a transaction and that is not in a significantly disparate bargaining position may by written contract waive the provisions of this subchapter, other than Section 17.555.
>
> (b) The existence or absence of a disparate bargaining position may not be established as a matter of law solely by evidence of the consumer's financial position relative to other parties to the contract or by matters contained in a written contract relating to the relative bargaining position of the parties.

TEX. INS. CODE ANN. art. 1.14-1, § 2 (Vernon 1981)—See Appendix D.

TEX. BUS. & COM. CODE ANN. § 17.46 (Vernon 1987)—See Appendix D.

TEX. INS. CODE ANN. art. 21.21 (Vernon 1981)—See Appendix D.

STATEMENT OF THE CASE

Ariens Company ("insured") manufactured and sold motorized lawn equipment. It held a liability policy with Columbia which provided a $100,000 per occurrence and $750,000 aggregate per policy period "self-insured retention." Columbia insured to limits of $1,000,000 per occurrence and $5,000,000 aggregate coverage, which the policy on its face termed "commercial umbrella liability" coverage. National Union provided excess coverage of $15 million. A special endorsement in the policy between Columbia and the insured deleted Columbia's right to settle

within the "retained" limit without the insured's consent. Under the terms of the policy, Columbia did have the "right to associate itself with the insured in the control of the negotiation, investigation, defense or appeal of any claim."

A products liability claim was settled for $7.5 million dollars. Although Columbia's involvement in the settlement is undisputed, the extent of their involvement is.

National Union sued Columbia for breach of its duty to negotiate a settlement with the plaintiffs in that lawsuit within the limits of its policy under Texas statutory and common law. National Union seeks return of its contribution to the settlement.

The federal courts have thus far sustained Columbia's motion for summary judgment on the grounds that the policy required the insured to defend and settle claims against it, that the insurer owed no duty under the policy language to the insured; and therefore National Union could not subrogate under the doctrine of equitable or contractual subrogation; and that, as a matter of law, the conduct of the insurer in actually conducting the negotiations without even notifying the insured of the offers it was making or the fact that it could have settled the claim within its policy limits, much less obtaining the insured's permission or input, did not create a duty to act with care as to those negotiations. They have held that the lack of such a duty under the policy terms as they erroneously construe them renders moot applicable Texas statutory and common law duties of Columbia.

FEDERAL JURISDICTION

Columbia effected removal to federal court based on the diversity of citizenship between National Union, a Pennsylvania corporation, and Columbia, an Illinois corporation. 28 U.S.C. § 1332 (1988). The underlying claim occurred in and was litigated in Trinity County, Texas.

ARGUMENT

I. Whether the Court of Appeals erroneously construed Texas substantive law in affirming the grant of summary judgment for the insurer by finding that a self-insured retention with limited rights to approve settlements transforms an insured into a primary carrier and destroys the duties owed to the insured by the insurer.

The Court of Appeals misconstrued Texas substantive law in affirming the grant of summary judgment. In reviewing diversity cases, the federal courts are obligated to apply applicable state law and policy. 28 U.S.C. § 1652 (1948); *Angel v. Bullington*, 330 U.S. 183, 191-92 (1947). Unfortunately, federal courts are at a distant disadvantage when considering cases in complex, rapidly changing areas such as Texas insurance law, that are seldom heard in federal court.

The federal district court committed several legal errors in its grant of summary judgment affirmed by the Court of Appeals. First, it treated the self-insured as a primary carrier. *National Union Fire Insurance Co. v. CNA Insurance Companies and Columbia Casualty Company,*

No. 9:90cv55, slip op. at 3, 4 (E.D. Tex. July 16, 1993) [hereinafter *D.C.*]. Under Texas law, self-insurance is not recognized as insurance, *Allstate v. Zellars,* 462 S.W.2d 550, 552 (Tex. 1970); *Home Indemnity v. Humble Oil & Refining Co.,* 314 S.W.2d 861, 865 (Tex. Civ. App.—Dallas 1958), *writ ref'd per curiam,* 317 S.W.2d 515 (Tex. 1958). Self-insurance lacks the element of spreading risk. "Risk is the essential subject of the contract of insurance and until the risk commences the insurance does not attach." 12 APPLEMAN, INSURANCE LAW AND PRACTICE § 7004 (1981). Even this court has recognized this most basic of precepts, *Group Life & Health Insurance Company v. Royal Drug Company,* 440 U.S. 205, 214 n. 12 (1979).

The federal courts' determination that the insured was the primary insurer, *National Union Fire Insurance Companies,* 28 F.3d 29, 30 n. 1 (5th Cir. 1994) [hereinafter *Ct. of App.*]; *D.C.* at 3 and 4, is premised on the proposition that among carriers, the carrier with the duty to defend assumes the role of primary carrier. *D.C.* at 3, n. 2. The district court, *D.C.* at 12, based this determination on *International Insurance Company v. Dresser Industries, Inc.,* 841 S.W.2d 427 (Tex.App.—Dallas 1992, no writ), where the insured agreed in the insuring agreement to assume the role of primary carrier under the policy, *Id.* at 440, assumed exclusive control over products liability claim settlement authority, *Id.* at 446, and stipulated for the purposes of the summary judgment under review that it agreed to assume the role of the "primary insurer" under the policy, *Id.* at 441. Despite these material factual distinctions from the case at hand where no such agreement existed and the *Dresser* court's reservation of its ruling to the facts of that case, *Id.* at 444, the federal district court simply applied

the assumption to this case, which involved only the limited right to reject a settlement. The Fifth Circuit followed suit by declaring the policy language to have unambiguously relieved the insurer of any duty to defend. *Ct. of App.* at 33. Both courts anoint the insured as the "primary carrier" by a judicial sleight of hand.

In distancing themselves from Texas law, both courts make a quantum leap in legal reasoning in assuming that if the insured retained any control over the defense, it assumes the role of primary carrier. In so doing, these federal courts totally ignore the state law and policy they are bound to follow in diversity cases. 28 U.S.C. § 1652 (1948). Therefore, the assumption that the duties of the primary carrier fall to the insured in a vacuum is ludicrous, unsupported by any applicable Texas legal authority, and constitutes legal error by the lower courts. If the federal courts are truly to function as state courts in diversity cases, as Justice Frankfurter opined in *Angel v. Bullington*, 330 U.S. at 187, they have erred in ignoring Texas law in their rulings.

II. Whether the Court of Appeals erroneously construed Texas substantive law in affirming the grant of Columbia's summary judgment and the denial of National Union's partial summary judgment in holding that the insured exercised the exclusive control over the defense and negotiations, and that under the policy, the insurer owed no duty to the insured to negotiate or settle the claim.

Under Texas law, the plain language of the policy is

the first rule of interpretation of an insurance policy. *Royal Indemnity Co. v. Marshall*, 388 S.W.2d 176, 181 (Tex. 1965). The federal courts, however, ignored the parties' clear intent as expressed in the policy language in holding that the insurer had no duty to the insured to settle the claim. The policy language only gave the insured the right to reject any negotiated settlement:

> The rejection of a **negotiated settlement for a definite amount** by the insured with respect to a claim shall limit the company's liability to the total amount of the settlement negotiated and defense costs incurred to the date of such negotiated settlement agreement for such claim less the self-insured retention. *Ct. of App.* at 32 (emphasis added).

This endorsement modifies the standard policy language which had previously given the insurer absolute control over settlements by giving the insured the limited right to reject negotiated settlements in exchange for limiting the insurer's liability in such circumstances to the amount the insurer had decided the case should have been settled for. (It should be obvious that if the insured had done the negotiations in the first place, it would not "reject" a settlement it had negotiated itself.) The federal courts erroneously interpreted this language to shift handling of settlement negotiations to the insured, which contradicts the plain language of the endorsement. *Ct. of App.* at 32, 33; *D.C.* at 9. An insured can hardly "reject" a settlement it itself negotiated. Rather, the endorsement language clearly contemplates a settlement negotiated by another party and presented to the insured for approval or rejection—obviously the other party to the policy contract,

the insurer, with its professional claims staff and claims handling experience.

Finally, if this policy language is ambiguous, Texas law requires that any ambiguities be resolved in favor of the insured, *Old Republic Insurance Company v. Comprehensive Health Care Associates,* 2 F.3d 105 (5th Cir. 1993). Under this rule of interpretation the court erred in its application of Texas law if it concluded that the insurer had been relieved of its duty to negotiate. Under Texas law, if the policy provision were capable of more than one reasonable interpretation then the interpretation providing coverage would control. *Id.*

For this reason, the trial court and the Court of Appeals both erred in failing to render a partial summary judgment for National Union as to the meaning of the policy provision in question. This Honorable Court should grant such partial summary judgment declaring that the policy provision requires the insurer to conduct the negotiations and present a negotiated settlement to the insured which it may approve or reject, but if it rejects the settlement, then the insurer's liability is limited to the amount of the claimant would have been willing to accept and the insurer would have been willing to pay.

III. Whether the Court of Appeals erroneously construed Texas substantive law in affirming the grant of summary judgment by ruling that the insurer's actual documented role in the handling of the claim, including the exclusive handling of settlement negotiations, as a matter of law, did not create a duty of reasonable

> care to the insured regardless of the policy provisions.

Texas courts have established that even one who owes no legal duty to another, but who gratuitously assumes to act, must conduct its actions with reasonable care. *Otis Engineering Corporation v. Clark*, 668 S.W.2d 307, 309 (Tex. 1983); *Colonial Savings Association v. Taylor*, 544 S.W.2d 116, 119-120 (Tex. 1976). Texas courts have found that this rule of law can apply to circumstances where an insurer with no contractual duty to defend assumes a role in the defense. *State Farm Fire & Casualty Company v. Gandy*, 880 S.W.2d 129, 135-136 (Tex. App.—Texarkana 1994, no writ).

The extent of the insurer's role in the settlement is obviously disputed, *Ct. of App.* at 33. The Court of Appeals, however, ruled that the extent of participation in the settlement by the insurer was immaterial because of its other ruling in this case that the insured retained control of the settlement under the policy. Under Texas law, the point is anything but immaterial. The *Gandy* court had similarly determined that the carrier owed no duty to defend under the policy, but nonetheless upheld an action under the Texas Deceptive Trade Practices Act, TEX. BUS. & COM. CODE ANN. § 17.46 (Vernon 1987)[hereinafter DTPA], based on the jury finding that the insurer failed to exercise reasonable care in the settlement negotiations and therefore was in breach of the duty it owed the insured by its voluntary participation in the settlement. *Gandy*, 880 S.W.2d at 135-6. And its liability for negligently performing acts was independent of whether it had any obligation to perform the acts in the first instance. *Gandy*, 880

S.W.2d at 134. Therefore, even if the court were correct in its statement that the insurer originally had no duty to negotiate, once it undertook to do the negotiation, it had to do so carefully. Fact issues are certainly raised as to whether it did, indeed, conduct the negotiations as a reasonable insurer would have done in the exercise of ordinary care. Exhaustive portions of the depositions of the witnesses were cited for the trial court and the Court of Appeals. These proved clearly that the insurer did all the negotiations and actually controlled the defense of the underlying claim against the insured, Tr. 245-60, Appendix E.

The trial court and court of appeals ignored National Union's summary judgment evidence that Columbia had exclusive control over the defense and settlement of the claim. According to the corporate counsel of the insured, Columbia had not asked the insured when it settled prior small cases under the policy, Tr. 420, and he and the owner of the insured relied on Columbia for direction on claims. Tr. 405-7; 431. Insured's corporate counsel was never apprised by Columbia of their evaluation that they had only a thirty percent chance of winning a case in which an adverse verdict in the $2—3 million range was predicted, Tr. 421-2, he was not made aware of settlement offers during the trial, Tr. 425, and he never had contact with Columbia during the trial, Tr. 432-4. Claims counsel testified he got his authority from Columbia, not the insured, Tr. 523. Columbia acknowledged that insured never failed to consent to settle at any time, Tr. 457-8, and that they exercised control over the defense and settlement of this case, Tr. 518-21. Extensive evidence providing further detail of Columbia's control of the defense and settlement of the case is contained in Appendix E.

The above evidence does far more than establish a material fact issue over control of the settlement. It establishes that Columbia had exclusive control over the defense and settlement of this claim as a matter of law. Ragardless of the policy provisions, this fact precludes summary judgment under Texas law.

At the very least, the Fifth Circuit erred by misapplying Texas law in holding that if the insured had exclusive control of the settlement negotiations under the policy (which it did not), there could not be any duty to the insured by the insurer in the settlement. Second, the Fifth Circuit erred in declaring that the level of the insurer's participation in this settlement, as evidenced by the insured's summary judgment evidence, did not "constitute assumption of the defense," citing itself. *Arkwright-Boston Mfrs. Mut. Ins. Co. v. Aries Marine Corp.*, 932 F.2d 442, 445-46 (5th Cir. 1991). This case is not even remotely determinative of the question presented here. The case only holds that conducting negotiations (a totally different obligation than the obligation to defend) does not constitute "defending." It does not hold that the actual negotiations by an insurer does not create duties to do so carefully, nor that the actual control over the negotiations is not evidence that the insurer is "negotiating" the claim.

The *Arkwright-Boston* case involves a Texas insured but finds no Texas law on point, and applies other federal decisions and maritime law to reach its conclusion on the excess carrier's duties once it participates in the defense. *Id.* The *Gandy* case, on the other hand, establishes that under Texas law, control of the defense is not the legal issue in examining the duty the insurer owed the insured in

settlement negotiations. *Gandy,* 880 S.W.2d at 135-6.

The Court of Appeals ignored the evidence as to control of the negotiations in the case and failed to differentiate the general defense of the lawsuit against the insured from the totally separate contractual obligation to negotiate and to present a "negotiated settlement" to the insured for its approval or rejection. In fact, the Court of Appeals failed to offer any rationale for not following the Texas law establishing a duty of reasonable care and cooperation in settlement among multiple insurers covering the same occurrence to each other and the insured:

> The reserved right of each insurer with respect to settlement was an equal one, which, however, could not be effectively exercised without reasonable cooperation on the part of the other. We think under the facts of this case each insurance company owed the duty to the other and to the assured to exercise ordinary care in deciding whether it would or would not cooperate with the other in consummating any settlement proposed by the injured claimant.

Employers Casualty Co. v. Hicks Rubber Co., 160 S.W.2d 96, 100 (Tex. Civ. App.—Waco, 1942), *rev'd on other grounds,* 169 S.W.2d 142 (Tex. 1943). Yet the Court of Appeals utterly failed to recognize or apply Texas substantive law or consider *Employers Casualty Co. v. Hicks Rubber Co.,* or other relevant Texas authorities as it is obligated to do in diversity cases.

IV. Whether Court of Appeals erroneously construed Texas substantive law in affir-

> ming the grant of summary judgment on an insurer's duties to the insured by ruling that Texas law imposes no duty on an insurer to attempt to settle within policy limits and that the insurer is not answerable to the insured if it does not.

In ignoring its appropriate function in diversity cases and established Texas law, the federal courts erroneously stated that Texas law imposes no duty on an insurer to attempt to settle within policy limits, and that the insured has no recourse if the insurer does not attempt to settle. *D.C.* at 14; *Ct. of App.* at 35. This conclusion is based solely on the courts' erroneous assumption that the insured, and not Columbia, assumes the role of the primary carrier. Their only legal authority is a Texas case that held that the duty of good faith and fair dealing in settlements was only available under the facts of that case to an excess carrier through equitable subrogation, not through a direct cause of action. *American Centennial Insurance Company v. Canal Insurance Company,* 843 S.W.2d 480 (Tex. 1992). National Union is suing under both its equitable subrogation rights from the insured, which the Fifth Circuit acknowledged, *Ct. of App.* at p. 31, as well as under its contractual subrogation rights provided in the policies in this case.

Texas law unambiguously recognizes an insured's cause of action for an insurer's failure to reasonably handle settlement negotiations. *Ranger County Mutual Insurance Company v. Guin,* 723 S.W.2d 656, 659 (Tex. 1987); *American Centennial,* 843 S.W.2d at 482; *American Physicians Insurance Exchange v. Garcia,* 876 S.W.2d 842, 848

(Tex. 1994); *Texas Farmers Insurance Company v. Soriano,* 881 S.W.2d 312, 314 (Tex. 1994). As the equitable subrogee of the insured, National Union succeeds to those rights.

The federal district court committed gross error in failing to recognize this cause of action. The Court of Appeals compounded this error in its affirmance.

V. Whether the Court of Appeals erroneously construed Texas substantive law in affirming the lower court's ruling that the excess carrier could not be entitled to contractual subrogation.

The Court of Appeals further misapplied Texas law by holding that an excess carrier **cannot** be entitled to contractual subrogation. *Ct. of App.* at 33. The Texas authority cited for that proposition, *American Centennial,* 843 S.W.2d at 483-5, does not support such a holding. It merely held that in a situation where an adequate remedy of equitable subrogation already existed, it would decline to extend a common law duty of good faith and fair dealing to the settlement.

National Union's contractual subrogation claim is based on the contractual duty the insurer owed it under the policies in this case. The federal courts erred by using Illinois law to find that no duty is owed an excess carrier if the lower level carrier lacked the authority to settle. *Ct. of App.* at 33, n. 5 (citing *Certain Underwriters v. Fidelity and Casualty Ins. Co.,* 789 F.Supp. 927, 934 (N.D. Ill. 1992), *rev'd on other grounds,* 4 F.3d 541 (7th Cir. 1993)). This case is not the controlling law in Texas, but even if it were, the insurer did have the authority to settle, subject to the

insured's limited rejection rights, and it was contractually obligated to National Union to act in the interests of all concerned. Section 14 of the Columbia Casualty policy with National Union states:

> SUBROGATION AND OTHER RECOVERIES: In the event of any payment under this policy, this company shall be subrogated to all the insured's rights of recovery therefor against any person or organization and the insured shall execute and deliver instruments and papers and do whatever else is necessary to secure such rights. The insured shall do nothing after injury or destruction to prejudice such rights. In the event that this paragraph is inconsistent with the provisions of the immediate underlying policy, with respect to Coverage A the provisions of the immediate underlying policy shall apply.
>
> Because this policy affords excess insurance, the insured's right of recovery cannot always be exclusively subrogated to the company. **It is, therefore, agreed that this company shall act in concert with all other interests concerned, including the insured, in the enforcement of any subrogation rights or in the recovery of amounts by any other means.** The apportioning of any amounts so recovered shall follow the principle that any interest, including the insured, that shall have paid an amount over and above any payment under this policy shall first be reimbursed up to the amount paid by such interest; this company shall then be reimbursed out of any balance then remaining up to the amounts paid as the

> result of loss covered under this policy; and lastly, the interests, including the insured, of whom the insurance is in excess are entitled to claim any residue remaining. Expenses and costs necessary to the recovery of any such amounts shall be in the ratio of the respective amounts sought to be recovered.

Columbia Casualty policy with National Union § 14, Tr. 583-4 (emphasis added). The policy issued Columbia by National Union is a "following form" policy, which adopts the same provisions as the underlying policy. The above quoted provisions, therefore, pertain to the agreement between Columbia and National Union as well.

The courts of Texas have never held that such a cause of action cannot be recognized.

VI. Whether the Court of Appeals erroneously construed Texas substantive law in holding that Texas statutory duties imposed under the Texas Deceptive Trade Practices Act can be contractually waived in policy provisions and are mooted by the court's contractual and tort analysis.

To grant the summary judgment the federal courts specifically held that their contractual and tort analysis rendered moot the applicable Texas statutes. *D.C.* at 19; *Ct. of App.* at 34 n.6. The duties created under the Texas statutes sued upon do not hinge on the policy provisions. Indeed they are consumer protection provisions designed to protect the public in insurance transactions. The DTPA itself strictly limits the ability to waive its causes of action by contract. TEX. BUS. & COM. CODE ANN § 17.42 (Vernon

Supp. 1994). The causes of action it creates are independent of common law duties, and it is immaterial whether common law negligence duties exist for these separate causes of action. Texas courts have found that common law defenses generally cannot defeat a claim under the DTPA. *Watkins v. Hammerman & Gainer,* 814 S.W.2d 867, 870 (Tex. App.—Austin 1991, no writ).

The federal courts failed to consider that the Texas statutes that apply to this case require a determination of the material fact question of the reasonableness of Columbia's actions in handling the settlement. The Texas common law duty of good faith and fair dealing can serve as the basis for a violation of TEX. BUS. & COM. CODE ANN. § 17.46 (Vernon 1987) and TEX. INS. CODE ANN. art. 21.21 (Vernon 1981). *Allied General Agency v. Moody,* 788 S.W.2d 601, 604 (Tex. App.—Dallas 1990, writ denied).

For the purposes of the DTPA, a carrier like the insurer, even if it previously owed no legal duty to the insured in the settlement, which nevertheless assumes a role in the defense or in negotiations, has a duty of reasonable care to prevent harm to others in the settlement. *Gandy,* 880 S.W.2d at 135; *Otis Engineering Corporation,* 668 S.W.2d at 309-311 (Tex. 1983). The insured in this case fell within the statute's definition of "consumer." *Gandy,* 880 S.W.2d at 135.

The insured, of course, also is not a licensed insurance carrier in Texas, nor a "carrier," TEX. INS. CODE ANN. art 1.14 § 2 (Vernon 1981), nor is it "engaged in the business of insurance" for the purposes of the Texas Insurance Code, TEX. INS. CODE ANN. art. 1.14-1, § 2 (Vernon 1981).

These statutory violations do **not** depend on, nor are they superseded by, policy provisions to the contrary. A diversity case should not be decided on a previous Fifth Circuit ruling that conflicts with Texas law. Yet the Court of Appeals ignores Texas law and cites its own opinion, *Arkwright-Boston Mfrs. Mut. Ins. Co.*, 931 F.2d at 445-46, as establishing as a matter of law that an insurer's participation in settlement negotiations does not create an assumption of insured's defense. *Ct. of App.* at 4. This case begs the question of whether the actual conduct of the negotiations constitutes the assumption of the duty to negotiate carefully, or constitutes assumption of the negotiations (not defense) aspect of the claim against the insured. It is immaterial whether negotiation constitutes assuming the entire defense. It certainly constitutes assumption of the negotiations, the actions upon which its *Stowers* duties were breached.

CONCLUSION

For the foregoing reasons, National Union respectfully urges this Court to reverse action of the Court of Appeals in the affirmance of the trial court's granting of summary judgment, and grant National Union's Motion For Partial Summary Judgment as to the correct interpretation of the policy language in question, and that it remand this case to federal district court for trial on the merits consistent with its rulings.

Respectfully submitted

Bob Roberts

CERTIFICATE OF SERVICE

I do hereby certify that true and correct copies of the foregoing Petition for Writ of Certiorari has been served this day upon all parties by placing same in the United States mail, first-class, prepaid postage to:

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APPENDIX A

Fifth Circuit Opinion
pursuant to S.Ct. Rule 14.1(k)(i)

(Cite as: 28 F.3d 29)

NATIONAL UNION FIRE INSURANCE CO.
OF PITTSBURGH, PENNSYLVANIA,
Plaintiff-Appellant,

v.

CNA INSURANCE COMPANIES and
Columbia Casualty Company,
Defendants-Appellees.

No. 93-5344.

United States Court of Appeals,

Fifth Circuit.

Aug. 10, 1994.

Rehearing Denied Sept. 6, 1994.

Before GARWOOD and EMILIO M. GARZA, Circuit Judges, and HEAD,* District Judge.

EMILIO M. GARZA, Circuit Judge:

National Union Fire Insurance Company ("National Union"), an upper-level excess insurance carrier, brought an action against a lower-level excess insurance carrier, Columbia Casualty Company ("Columbia"), claiming that Columbia had breached either a direct or indirect duty to National Union to settle litigation brought against the mutual insured Ariens Company ("Ariens"). On appeal, we must determine whether the district court erred in granting summary judgment in favor of Columbia. Finding no error, we affirm.

I

The underlying facts are undisputed. Ariens manufactured and sold motorized lawn and garden equipment, such as lawn mowers, snow blowers, and stump grinders. A four-year-old boy was attempting to operate one of Ariens's riding rotary lawn mowers. The rotary blade got caught on a root. The boy got off the mower without killing the engine or disengaging the mower blade, and places both his hands and arms under the mower in an attempt to free the blade. When the blade was freed, it amputated the boy's hands and one arm almost to the elbow.

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* District Judge of the Southern District of Texas, sitting by designation.

The victim's parents (the "*Hines* plaintiffs") brought a products liability suit in state court against Ariens, claiming that the lawn mower's defective design caused the injuries described above. Apparently, later models of the insured's mowers were equipped with switches which killed the engine if the rider left the mower seat while the blade was engaged. The mower involved in this case did not have such a feature. Ariens defended liability on the ground that a riding lawn mower could not be made safe for use by a four-year old. Ariens also sued the *Hines* plaintiffs for indemnity, claiming that they were negligent in allowing the boy to operate the mower.

Ariens was self-insured up to $100,000 per occurrence, and $750,000 in the aggregate of all claims made in any one policy period. Beyond this self-insurance layer, Columbia provided the first and second levels of excess coverage, providing $1 million, less the insured's self-retained limits, and $5 million, respectively. National Union provided the outermost layer of $15 million of coverage, in excess of Columbia's second layer of coverage.[1] The excess liability policy between Ariens between Ariens and Columbia gave Columbia the "right to associate itself with the insured in the control, negotiation, investigation, defense or appeal of any claim." Special Endorsement 6 of the policy also deleted Columbia's "right to settle [any] claim or suit for an amount within the Insured's

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[1] "Excess liability insurers contract to provide inexpensive insurance with high policy limits by requiring the insured to contract for primary

Retained Limit," without the consent of the insured. Ariens retained its own counsel. After a large verdict in favor of the *Hines* plaintiffs, Ariens settled the case for $7.5 million. The settlement exhausted Arien's self-insured limits and the first two layers of excess coverage provided by Columbia, causing National Union to contribute approximately $2 million to the settlement.

[1,2] National Union subsequently sued Columbia, claiming that Columbia breached either a direct or indirect duty to National Union by not negotiating a settlement with the *Hines* plaintiff's for an amount within the first two layers of excess coverage. As damages, National Union sought to recover the amount it had to contribute to the settlement of the underlying action. Columbia moved for summary judgment on the ground that it owed no legal duty to either Ariens or National Union to engage in settlement negotiations, since the excess coverage policy be-

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footnote 1 continued.

insurance with another carrier. The premium is also held down by the fact that the duty to defend rests primarily on the primary insurer...."*Harville v. Twin City Fire Ins. Co.*, 885 F.2d 276, 278-79 (5th Cir. 1989)(footnote omitted). Here, Columbia contends that Ariens was both self-insurer and primary insurer, to the extent that Ariens contracted to retain control over defense of the claim, including the handling of settlement negotiations. Columbia and National Union, by the express terms of their respective policies with the insured, were both excess liability insurers.

tween it and the insured merely allowed, rather than required, that Columbia "associate itself with the insured in the control, negotiation, investigation, defense or appeal of any claim." The district court concluded that the terms of Special Endorsement 6 did not create a duty on behalf of Columbia toward Ariens to negotiate a settlement. The court further concluded that because Columbia owed no duty to Ariens, Columbia also owed no duty to National Union under the doctrine of equitable subrogation.[2] Based on these conclusions, the court granted summary judgment in favor of Columbia, from which National Union timely appealed.

II

[3-5] We review the district court's grant of a summary judgment motion de novo. *Davis v. Illinois Cent. R.R.*, 921 F.2d 616, 617-18 (5th Cir. 1991). Summary judgment is appropriate if the record discloses "that there is no genuine issue of material fact and that the moving party is entitled to a judgment as a matter of law." Fed.R.Civ.P.56(c). A party seeking summary judgment bears the initial burden of identifying those portions of the pleadings and discovery on file, together with any affidavits, which it believes demonstrate the absence of a genuine issue of material fact. *Celotex Corp. v. Catrett*, 477

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[2] Equitable subrogation is the legal fiction through which a person who pays the debt for which another is primarily responsible is substituted, or subrogated, to all rights and remedies of the other. Black's Law Dictionary 539 (6th ed. 1990). In Texas, an excess insurer may bring an equitable subrogation action against a primary insurer—i.e., an action that the insured may have against the primary insurer for mishandling a claim. *See American Centennial Ins. Co. v. Canal Ins. Co.*, 843 S.W.2d 480,482-83 (Tex.1992).

U.S. 317,325, 106 S.Ct. 2548, 2554, 91 L.Ed.2d 265 (1986). Once the movant carries its burden, the burden shifts to the non-movant to show that summary judgment should not be granted. *Id.* at 324-25, 106 S.Ct. at 2553-54. While we must "review the facts drawing all inferences most favorable to the party opposing the motion," *Reid v. State Farm Mut. Auto. Ins. Co.*, 784 F.2d 577, 578 (5th Cir.1986), that party may not rest upon mere allegations or denials in its pleadings, but must set forth specific facts showing the existence of a genuine issue for trial. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242,256-57, 106 S.Ct. 2505, 2514, 91 L.Ed.2d 202 (1986).

[6-8] National Union first contends that the district court erred in construing the terms of the excess insurance policy between Columbia and Ariens as not requiring that Columbia negotiate a settlement within the first two layers of excess liability coverage. "In construing a written contract [such as an insurance policy], the primary concern of the court is to ascertain the true intentions of the parties as expressed in the instrument." *Coker v. Coker*, 650 S.W.2d 391,393 (Tex.1983).[3] When the terms of an insurance policy are plain, definite, and unambiguous, a court may not vary those terms. *Royal Indemnity Co. v. Marshall*, 388 S.W.2d 176, 181 (Tex.1965); *see also Barnett v. Aetna Life Ins. Co.*, 723 S.W.2d 663, 665 (Tex.1987) (stating that "if the insurance contract is expressed in

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[3] Because the laws of the various states involved in this diversity suit do not conflict on any material issue, we apply Texas substantive law. *See W.R. Grace & Co. v. Continental Casualty Co.*, 896 F.2d 865, 874 (5th Cir.1990) ("If the laws of the states do not conflict, then no choice-of-law analysis is necessary."). Even if some material conflict did exist, our application of Texas law renders moot National Union's argument that Texas law should apply.

plain and unambiguous language, a court cannot resort to the various rules of construction [favoring the insured]"). An insurance policy is ambiguous only when it is "reasonably susceptible to more than one meaning ... but if only one reasonable meaning clearly emerges[,] it is not ambiguous." *Universal C.I.T. Credit Corp. v. Daniel*, 150 Tex. 513, 243 S.W.2d 154, 157 (1951). When no ambiguity exists, a court must give the words used their plain meaning. *Puckett v. United States Fire Ins. Co.*, 678 S.W.2d 936, 938 (Tex.1984).

Special Endorsement 6 of the excess insurance policy provides in pertinent part:

> The [insurance] company, at its own expense, shall have [the] right to associate itself with the insured in the control, negotiation, investigation, defense or appeal of any claim or proceeding which, in the opinion of the company is or may be covered by this policy. The insured shall fully cooperate in all matters pertaining to such claim or proceeding....
>
> The rejection of a negotiated settlement for a definite amount by the insured with respect to a claim shall limit the company's liability to the total amount of the settlement negotiated and defense costs and excess defense costs incurred to the date of such negotiated settlement agreement for such claim less the self-insured retention.

Special Endorsement 6 also expressly deleted condition 3(d) from the insurance policy, which formerly read:

> The [insurance] [c]ompany at its sole option and without the consent of the insured, may settle any claim or suit involving the limits of liability of this policy or likely to involve

> its limits. The [c]ompany expressly reserves the right to settle such claim or suit for an amount within the Insured's Retained Limit.

[9,10] We read this unambiguous language to mean that Columbia had the *right,* and not the *duty* to engage in settlement negotiations. Indeed, the explicit abrogation of Columbia's unilateral auathority to negotiate a binding settlement supports the interpretation that the parties intended for Ariens to control its own defense, including the handling of settlement negotiations. *See also Inst. of London Underwriters v. First Horizon,* 972 F.2d 125, 126 (5th Cir.1992) (interpreting similar language under Louisiana law—"[the excess carrier] shall have the right and shall be given the opportunity to associate with the Assured or the Assured's underlying insurers or both in the defense and control of any claim...." —as unambiguously excluding a defense *obligation* on behalf of an excess carrier). Based on the policy's plain and unambiguous language, we hold, as the district court did, that Columbia had no duty to Ariens to settle for an amount within the first two layers of excess liability coverage.[4] Because Columbia had no duty to Ariens, Columbia also had no duty to National Union under the doctrine of equitable subrogation. *See American Centennial,* 843 S.W.2d 480, 482-83 (Tex.1992) (noting that the doctrine permits the excess insurer to step into the

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[4] We do recognize that the policy did impose the duty upon Columbia to "cooperate in all matters pertaining [a] claim or proceeding [in defense of litigation]." Given the undisputed fact that Columbia never objected to any settlement Ariens wanted to make, we hold as a matter of law that Columbia did not violate its duty to cooperate. See Record on Appeal vol. 2, at 781 (deposition of J. Michael Myers, counsel for Ariens) (stating that prior to the verdict coming in, Columbia had never refused to consent to an amount for which his client desired to settle).

shoes of the insured when pursuing a cause of action for mishandling of a claim).[5]

National Union also contends that it raised a material issue of fact regarding whether Columbia actually controlled the defense of the litigation against Ariens, thereby triggering a duty on behalf of Columbia to settle and/or defend the claim in a reasonable and careful manner. This argument fails to persuade for at least two reasons. First, the terms of the policy unambiguously reserves control of the defense to Ariens, and not Columbia. Thus, as a matter of law, Columbia could not have controlled the defense of the claim. Second the summary judgment evidence which National Union cites in its brief demonstrates at most that Columbia's adjuster participated in settlement negotiations with the Hines plaintiffs. We have held as a matter of law that where the insured has retained independent counsel, an insurer's participation in settlement negotiations does not itself constitute an assumption of the insured's defense. *See Arkwright-Boston Mfrs. Mut. Ins. Co. v. Aries Marine Corp.*, 932 F.2d 442, 445-46 (5th Cir.1991). We therefore re-

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[5] Although some jurisdictions have recognized a direct duty running from the primary to the excess insurer, Texas has yet to recognize such a duty. *See American Centennial*, 843 S.W.2d at 483 ("[W]e decline at this time to permit a direct action."). Even if Texas did recognize a duty running from a lower-level excess insurer to an upper-level excess insurer, to settle a claim within the lower-level coverage limits, the terms of the policy gave the Ariens, and not Columbia, the authority to control the defense of litigation, including settlement negotiations. Lacking such control, Columbia could not have possessed a duty to settle within the lower-level coverage limits. *See Certain Underwriters v. Fidelity and Casualty Ins. Co.*, 789 F.Supp. 927, 934 (N.D.Ill.1992) ("As a matter of law the primary insurer cannot have a direct duty to the excess insurer to do that which the primary insurer has no authority to do."), *rev'd on other grounds*, 4 F.3d 541 (7th Cir.1993).

ject Columbia's second contention on appeal.[6]

III

For the foregoing reasons, we AFFIRM the judgment of the district court.

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[6] Because we conclude that Columbia violated no duty to National Union, we further note tht the district court correctly granted summary judgment on National Union's claims under the Texas Deceptive Trade Practices Act and Insurance Code which were premised on Columbia's allegedly negligent conduct in failing to settle the litigation. See Brief for National Union at 35 ("The same evidence which constitutes negligence on the part of CNA also constitutes evidence of an unconscionable course of conduct which would violate both the DTPA and Art. 21.21, Insurance Code of Texas.").

APPENDIX B

District Court Order Granting Summary Judgment
pursuant to S.Ct. Rule 14.1(k)(ii)

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF TEXAS
LUFKIN DIVISION

National Union Fire Insurance Company	)	
Plaintiff,	)	
vs.	)	Civil Action No. 9:90cv55
CNA Insurance Companies and Columbia Casualty Company;	)	
Defendants.	)	

Order

Before the Court are the motion for summary judgment of Columbia Casualty Company, on its own Behalf and on Behalf of "CNA Insurance Companies" (referenced collectively herein as Columbia) and Plaintiff's response(s)

thereto; and the motion for summary judgment of Plaintiff National Union Fire Insurance Company, and Columbia's response(s) thereto.

Upon careful consideration, and for the following reasons, the Court is of the opinion that: (1) Columbia's motion for summary judgment must be **GRANTED**; (2) National Union's motion for summary judgment must be **DENIED**; and (3) Plaintiff's (entirely undeveloped) Texas Insurance Code and Texas Deceptive Trade Practices Act claims against Defendant are properly **DEEMED NECESSARILY ADJUDICATED THROUGH THE ANALYSIS CONTAINED IN THIS *MEMORANDUM OPINION AND ORDER.***

I. Introduction

This suit is brought by one excess insurance carrier, Pennsylvania Resident National Union, against a lower level excess carrier, Illinois Resident Columbia — for a breach of an alleged obligation on the part of Columbia toward National Union to attempt to settle a products liability case brought in Trinity County, Texas, against the parties' mutual insured, Wisconsin Resident Ariens Company (Ariens).[1] However, National Union asserts Columbia actually plays the part of primary insurer to Ariens.[2]

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[1] The underlying lawsuit is referenced as the "*Hines* case" (*Hines v. Ariens Co., et al*).

[2] "Primary" and "excess" insurers have been well-described in these ways:

> Simply stated, the primary policy provides "first dollar" liability coverage up to the limits of the policy, in some in-

The parties' mutual insured, Ariens, manufactures small engine power equipment (e.g., rider lawn mowers). In

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footnote 2 continued

> stances subject to a small deductible. Thus, where an insured has purchased solely a $100,000 single limit liability policy, only $100,000 in coverage is available to cover an occurrence for which the insured bears liability. ***
>
> *The primary insurance carrier is obligated not only to pay on behalf of the insured settlements and judgments, but also owes its insured a duty to defend under most policies.*
>
> * * *
>
> * * * *The duty to provide defense counsel to the insured and to pay these attorneys' fees distinguishes primary insurance from most policies of excess insurance. Most excess policies do not obligate the insurer to defend lawsuits filed against the insured.*

Michael M. Marick, Excess Insurance: *An Overview of General Principles and Current Issues,* 24 TORT & INS. L.J. 715, 715-716 (1989) (hereinafter, Marick, *Excess Insurance*) (quoting *Whitehead v. Fleet Towing Co.,* 110 Ill. App. 3d 759, 764, 442 N.E.2d 1362, 1366, 66 Ill. Dec. 449 (5th Dist. 1982)) (emphasis added).

Because the primary insurer adopts the duty to defend the insured and on average most claims brought against the insured fall within the primary's limits, the primary carrier charges a larger premium for an amount of coverage otherwise equivalent to that provided by the non-defending excess carrier. And because of its less frequent exposure, the excess carrier generally charges lower premiums.

The systemically stained relationship between the primary and the excess insurer has been explained quite well by Third Circuit Judge Joseph Weis:

> The relationship between the primary and excess carrier is an unusual one; each has a separate contract with the insured, but they have no contract with each other. Conflicts of interest invariably arise when the underlying tort injury is of such severity that a recovery over the limits of the primary policy is possible. In that circumstance, the excess carrier wishes the primary insurer to dispose of the case within its limits and is not unduly impressed with the primary insurer's desire to save some or all of its policy limits by a favorable verdict at trial. Conversely, the

1976, Ariens decided it could no longer abide its primary insurer's pattern of decisionmaking regarding the defense and settlement of legal claims brought against Ariens. Thus, Ariens negotiated for and purchased a new set of insurance policies. The essence of this new regime of insurance coverage is that Ariens retained the right to control the defense of litigation brought against it, including the right to approve or disapprove any offer of settlement.[3] Under the terms of the new insurance policies, Ariens was *self-insured* up to $100,000.00 per occurrence, and $750,000.00 in the aggregate of all claims made in any one policy period. Beyond this self-insurance layer, *Columbia* held the first layer of Ariens' excess coverage. This policy provided for indemnification for defense costs and other covered loss in an amount equal to the difference between the insured's retained limit of $100,000.00 ultimate net loss and the $1 million ultimate net loss. Beyond this

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footnote 2 continued

> primary carrier is unlikely to have such paternalistic feelings as will induce it to concede its limits when there is some chance of obtaining a favorable verdict. In each instance, one carrier is to some extent gambling with the other's money.

Puritan Insurance Co. v. Canadian Universal Insurance Co., 775 F.2d 76, 78 (3rd Cir. 1985) (citing Anthony M. Lanzone and Stephen G. Ringel, *Duties of a Primary Insurer to an Excess Insurer*, 61 NEB. L. REV. 259 (1982)).

[3] This retention of litigation control by Ariens is consistent with a general, well-recognized insurance industry phenomenon emergent in the 1970's and 1980's: "incremental utilization of the self-insured retention" (allowing the insured to control the handling of claims). Marick, *Excess Insurance, supra note 2.* National Union argues that the $100,000.00 self-insured limit is but a mere "deductible" and that, therefore, Columbia should be deemed a primary insurer by the Court irrespective of the fact that the policy under consideration is described as an "excess" policy. This argument fails to persuade.

first layer of excess coverage, *Columbia* issued another, "umbrella" layer of excess coverage. This umbrella policy provided for up to $5 million worth of coverage, "for loss in excess of the total applicable limits of liability of the underlying insurance." Finally, *National Union* issued a top layer of excess coverage to Ariens. This policy provided for up to $15 million in coverage, in excess of Columbia's Second Layer Umbrella Policy.

Ariens retained its own, outside counsel in the *Hines* case: J. Michael Myers, from Groce, Locke & Hebdon, in San Antonio, Texas. The jury returned a verdict against Ariens for $22.5 million.[4] The verdict ws remitted by the Trinity County, Texas, court to $15 million. Still, Ariens intimated its intent to appeal this judgment as manifestly unjust. But then, Ariens agreed to settle for $7.5 million.

National Union's claim against Columbia is that Columbia breached some duty — either direct or derivative — to National Union by not attempting to negotiate a settlement proposal on behalf of Ariens (and, thus, argues National Union, that Columbia owes National Union for the resulting "damage" suffered by National Union by being called upon to contribute to greater-than-otherwise *Hines* settlement). Specifically, National Union asserts that it should be reimbursed by Columbia for $1.96 million National Union was ultimately called upon to contribute to the *Hines* suit settlement *as a result* of Columbia's allegedly inappropriate, or "bad faith" settlement inaction relative to the *Hines* litigation.

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[4] Other defendants in the *Hines* trial announced their settlement for $1.5 million just prior to the verdict.

II. Analysis

Which Law Governs?
More Important: Does it Matter?

National Union argues that Texas law controls this case. In particular, National Union asserts Texas Insurance Code, art. 21.42 governs. The Court is not persuaded. *See W.R. Grace & Co. v. Continental Casualty Co.*, 896 F.2d 865, 883 (5th Cir. 1990) ("We are not persuaded that the language of [Texas Ins. Code Ann. art. 21.42] mandates the application of Texas law in this case where the contracts of insurance are not payable to Texas citizens or inhabitants").

Columbia argues the law of Wisconsin governs this case — in accordance with Texas' "most significant contacts" tests — as that is the home state of the parties' mutual insured, Ariens.[5] In brief, Columbia argues that Wisconsin law is applicable because "it is most clearly associated with the issuance and negotiation of the policies, their purchase and the expectations of the insured." Columbia Casualty Company's Brief in Support of Motion for Summary Judgment on its Own Behalf and on Behalf of "CNA Insurance Companies," p. 5 (citing

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[5] A Texas federal district court is obliged to apply the conflicts of law rules prevailing in Texas state courts in determining the applicable substantive law in a case. *Brown v. Cities Serv. Oil Co.*, 733 F.2d 1156, 1159 (5th Cir. 1984). And under Texas' conflicts rules, in all conflicts cases (excepting those contract cases in which the contracting parties have agreed to a valid choice of law clause), the law of the state with the most significant relationship to the particular substantive issues will be applied. *Duncan v. Cessna Aircraft Co.*, 665 S.W.2d 414, 420-421 (Tex. 1984).

Austin Bldg. Co. v. National Union Fire Ins. Co., 432 S.W.2d 697, 700-701 (Tex. 1968)). But the Court has some concern that, given the significant ramifications of this case for Illinois Resident Columbia, and similarly situated Illinois insurance companies, Illinois might actually be the state with the most significant relationship to this matter.

Yet, there is no need for the Court to *decide* a conflicts question. The laws of all three possible "choice of law" states — Illinois, Texas, and Wisconsin — do not actually *conflict* on the issues presented in this case; and so there is no *need* for the Court to *make a choice* of law. *W.R. Grace & Co. v. Continental Casualty Co.*, 896 F.2d 865, 874 (5th Cir. 1990) (court need not make a choice-of-law determination because the laws of the various states are not in conflict regarding the relevant issues); accord *Union Sav. American Life v. North Cent. Life*, 813 F. Supp. 481, 493 (S.D. Miss. 1993). *See also International Adm'rs v. Life Insurance Co.*, 753 F.2d 1373, 1376 n.4 (7th Cir. 1985) ("Conflict rules apply only where a difference in law makes a difference to the outcome"). In short: even under the Texas law championed by National Union, Columbia is entitled to summary judgment, and National Union's motion for summary judgment must be denied.

Merits: Introduction

Of course, Federal Rule of Civil Procedure 56 mandates summary judgment in any case where a party bearing the burden of proof fails to establish an essential element of its case. *Celotex Corp. v. Catrett*, 477 U.S. 317, 322 (1986). Accord *Washington v. Armstrong World Indus., Inc.*, 839 F.2d 1121, 1122 (5th Cir. 1988). Summary Judg-

ment is called for if Plaintiff has failed to establish a genuine issue of material fact. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 247-248 (1986). As explained next, Plaintiff has generated no genuine issues of material fact relative to its claims against Columbia. It is clear, as a matter of law, that Plaintiff cannot succeed upon any theory it has pleaded. At best, National Union has generated a mere scintilla of doubt as to a material fact on an essential element in this case — which is inadequate to forestall the granting of summary judgment against National Union. *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 586 (1986) (to survive a motion for summary judgment, movant "must do more than simply show that there is some metaphysical doubt as to the material facts.").

A contract modification is a change in a contract that introduces new elements into the details of the contract and cancels still others, while leaving the general purpose and effect of the contract intact. And a contract may only be modified with the assent of the parties. *Certain Underwriters v. Fidelity and Casualty Insurance Co.*, 789 F. Supp. 927, 931 (N. D. Ill. 1992). Resolution of this controversy essentially centers on the "Special Endorsement No. 6" in the Ariens-Columbia policy. This provision takes the place of the previous "Defense Costs" section of the Ariens-Columbia policy. Special Endorsement No. 6 (emphasis added) provides:

> . . . the [insurance] company, at its own expense, shall have the *right to associate* itself with the insured in the control, negotiation, investigation, defense, or appeal of any claim or proceeding

> which, in the opinion of the company is or may be covered by this policy.The insured shall fully cooperate in all matters pertaining to such claim or proceeding. . . .
>
> The rejection of a negotiated settlement for a definite amount by the insured with respect to a claim shall limit the company's liability to the total amount of the settlement negotiated and defense costs and excess defense costs incurred to the date of such negotiated settlement agreement for such claim less the self-insured retention . . . .

Later in the Endorsement it is provided that Condition 3(d)" is thereby deleted from the policy. Condition 3(d) had provided:

> 3. Insured's Duties in the Event of Occurrence, Claim, or Suit.
>
> (d) The Company, at its sole option and without the consent of the insured, may settle any claim or suit involving the limits of liability of this policy or likely to involve its limits. . . .

In short, while it is clear Columbia retained the *right* to *voluntarily* become *associated with* the defense or negotiations relative to a claim brought against Ariens, Columbia in no way *obligated* itself to so associate.

National Union argues Columbia should have attempted to negotiate a settlement with the *Hines* plaintiff. This argument is untenable. The liability capping provision in Special Endorsement 6 is a *privilege enjoyed* and *not a*

duty borne by Columbia. And there was never any settlement negotiation for Columbia to associate with.

Re: National Union's Contract Theory

The policy under construction is a special manuscript policy written for Ariens after negotiation between it and Columbia. Insurance policies are interpreted under the general rules of contract construction. *Coker v. Coker,* 650 S.W.2d 391, 393 (Tex. 1983). The following is axiomatic: courts cannot *make* contracts. In construing a written contract such as an insurance policy, the primary concern of a court is to ascertain the intent of the contracting parties as expressed in the instrument. *Coker v. Coker,* 650 S.W.2d 391, 393 (Tex. 1983). To achieve this objective, a court should consider the relevant writing in its entirety, in an effort to harmonize and give effect to *all* provisions of the contract (i.e., in an attempt to avoid rendering any part of the contract meaningless). That is, no single provision is to be taken alone as providing controlling effect; rather, particular contractual provisions must be considered with reference to the whole instrument being interpreted. Coker, *id.*

With these basic principles of contractual construction in mind, the Court easily concludes that the insurance contract between Ariens and Columbia does not impose upon Columbia any duty to seek a settlement in the *Hines* case. National Union would have the Court engage in a tortuous reading of select provisions of the contract in order to "find" such a duty. But the Court cannot utilize its *interpretive powers to essentially create* the duty envisioned by National Union. As there is no ambiguity in the Ariens-

Columbia contract and the intent of the parties thereto is obvious, the Court must give effect to the parties' clear intentions as reflected in the contract language. *Glover v. National Insurance Underwriters,* 545 S.W.2d 755, 757 (Tex. 1977).

National Union unreasonably desires the Court to read the Special Endorsement 6 liability capping provision as a duty, or a "stick," when it is obviously intended to be but a *privilege,* or a "carrot" for Columbia.[6] And National Union's "construction" of the Ariens-Columbia contract(s) impermissibly renders part of the Endorsement meaningless. *See e.g., Blaylock v. American Guaranty Bank Liability Co.,* 632 S.W.2d 719, 722 (Tex. 1982) (insurance contract will not be interpreted so as to render meaningless the clear language adopted by the parties). *See also e.g., Jameson v. Mutual Life Ins. Co. of New York,* 415 F.2d 1017 (5th Cir. 1969) (to properly interpret a *policy* amendment, the court must ascertain appropriate overall construction of policy "boilerplate" and then amend that "boilerplate" by giving the language used in the amendment its usual and common meaning).

It is clear that Ariens and Columbia sought to delete

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[6] This contractual provision is not unlike the Offer of Judgment device under Federal Court Rules.*See generally* FEDERAL RULE OF CIVIL PROCEDURE 68; UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT of TEXAS, CIVIL JUSTICE EXPENSE AND DELAY REDUCTION PLAN, Art. Six, (9) Offer of Judgment ("At the Management Conference or anytime thereafter, a party may make a written offer of judgment. If the offer of judgment is not accepted and the final judgment in the case is of more benefit to the party who made the offer by 10%, then the party who rejected the offer must pay the litigation costs incurred after the offer was rejected.").

their old policy's Condition 3(d) and to amend the old policy's Defense Costs section — so as to effectuate a coverage scheme in which (just like self-insured Dresser in *International Insurance Co. v. Dresser Industries,* 841 S.W.2d 437 (Tex. App.—Dallas 1992)) Ariens wore "two hats;" that of "the insured;" and that of "the primary, self-*insurer.*" The "Ariens as primary, self-insurer" hat reflected in the contract(s)-as-amended is a special one for which Ariens and Columbia bargained. Ariens negotiated for the ability to insure control over its own litigation. It had good business reasons for taking on such a responsibility — i.e., to avoid or forestall another, traditional primary insurer from controlling the litigation of claims brought against Ariens. *See* Kent Syverud, *The Duty to Settle,* 76 VA. L. REV. 1113, 1181 (1990) (recognizing insured's interest in litigation "involves additional, uninsurable stakes beyond the money handed over to the plaintiff" such as reputation, self-image, and other reasonable business concerns) (*cited in International Insurance Co. v. Dresser Industries,* 841 S.W.2d 437, 444 (Tex. App.—Dallas 1992)).[7] Columbia, meanwhile, retained a valuable right of choice — i.e., as to whether or not to invoke its liability capping provision in a particular case, in order to cap its apparent exposure in a case defended by Ariens.

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[7] *Cf. e.g., Brion v. Vigilant Insurance Co.,* 651 S.W.2d 183, 184 (Mo. App. 1983):

> The provision of the insurance contract . . . requires [the insured's] consent prior to settlement of any . . . suit against him. This is essentially a "pride" provision which gives appellant control over litigation which could jeopardize his professional reputation. The control given to appellant by the terms of the insurance contract is a valuable right. We can assume [the insured] paid an additional premium for this control.

Re: National Union's Tort Theory of Equitable Subrogation

National Union also raises tort theories. The first of these is the concept of equitable subrogation. Under this doctrine, the rights of the excess carrier are tantamount to the rights of the insured. The excess carrier stands in the shoes of the insured. *See e.g., American Centennial Ins. v. Canal Ins. Co,* 843 S.W.2d 480 (Tex. 1992). Thus, the insured's conduct becomes a significant consideration. Under the theory of equitable subrogation, excess carriers are subject to any defenses assertable against an insured (e.g., the refusal to settle and the failure to cooperate).

Of course, *when an insurer undertakes the duty to defend its insured,* the insurer has a duty to attempt to settle a claim against its insured within the policy limits when a reasonable attorney would do so. *See Stowers Furniture Co. v. American Indemnity Co.,* 15 S.W.2d 544 (Tex. Comm. App. 1929). And the insurer in such a circumstance is also obligated to act as an ordinarily prudent person in business management would with respect to *claim investigation, trial defense and settlement negotiations. See Stowers Furniture Co. v. American Indemnity Co.,* 15 S.W.2d 544 (Tex. Comm. App. 1929); *Ranger County Mutual Insurance Co. v. Guin,* 723 S.W.2d 656, 659 (Tex. 1987).

Thus, under the *traditional primary insurance policy,* a general duty on the part of the insurer to investigate the possibility for, and to seek the negotiation of a settlement is indeed triggered by the very making of a claim against an insured and the forwarding of notice of such claim to the insurer. This is so because such events trigger the primary

insurer's duty to handle litigation of a claim in a reasonable, good faith manner. But this case does not arise under the traditional scenario. Ariens "self-retained" its primary insurance coverage, including the duty/right to defend itself. In short, this case is fundamentally unlike the equitable subrogation cases cited by National Union.

First, had Columbia *exercised* the liability capping provision of its contract(s) with Ariens, the *insured's exposure to liability would have been increased.* Columbia's *abstention* from utilizing the liability capping provision inhered, per the apparent vision of the contracting parties, to the *benefit* of the insured. Thus, Columbia's reasonable business judgent to abstain from associating with Ariens' defense of the *Hines* litigation cannot be seen to carry the seeds of a cause of action by Ariens against Columbia; accordingly, such abstention cannot sustain National Union's equitable subrogation case against Columbia.

Further, in contrast to the Ninth Circuit case cited by National Union — *Valentine v. Aetna Ins. Co.,* 564 F.2d 292, 297 (9th Cir. 1977) — for example, the insurer under accusation in this case has not *frustrated* settlement efforts to the detriment of the accusing excess carrier. The uncontroverted summary judgment evidence is that at no time prior to trial in the *Hines* case did Ariens request any amount be paid by Columbia for settlement of the suit that Columbia refused to pay. Deposition of [Ariens' Outside Counsel in the *Hines* case] J. Michael Myers, at p. 138. Indeed, the uncontroverted summary judgment evidence is that Ariens' own management never believed there was an opportunity prior to the *Hines* trial for a settlement it considered reasonable under the circumstances. Affidavit of

[Ariens Senior Vice President, Finance] G. Roger McGrath, at ¶ 16; Deposition of G. Roger McGrath.[8] *See Certain Underwriters v. Fidelity and Casualty Insurance Co.*, 789 F. Supp. 927, 933 (N. D. Ill. 1992) ("Dresser [the insured] lacks a cause of action against Fidelity under an equitable subrogation theory because it is undisputed that Dresser would not settle the [underlying personal injury] Fahy claim. Since Fidelity breached no duty to Dresser, Underwriters [the upper layer, excess carrier] has no cause of action against Fidelity for failure to settle the Fahy claim. Therefore applying the law of equitable subrogation, the law does not afford Underwriters recovery.").[9]

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[8] National Union has launched an unpersuasive objection to the Court's summary judgment consideration of Mr. McGrath's affidavit — on the ground that he has not been properly designated by Columbia as an expert. Mr. McGrath's affidavit is not being considered by the Court as that of an *expert*.

In the positions he held with Ariens at the relevant times, Mr. McGrath reported directly to the president of that company. And Mr. McGrath's duties and responsibilities were all matters related to the financial condition of the company, *including such concerns as insurance coverage and the defense of product liability litigation*. The McGrath affidavit describes *inter alia*: how Ariens undertook to direct its own defense in the *Hines* lawsuit by retaining local counsel in San Antonio, J. Michael Myers (who reported to among others, Irving G. Curry III, Ariens' outside corporate counsel in Wisconsin, who in turn reported directly to Ariens); how Ariens institutionally viewed the *Hines* lawsuit as one of very limited liability; and how at "no time prior to the verdict in the *Hines* lawsuit was there an opportunity for a settlement which Ariens considered reasonable under the circumstances of that case."

[9] The Third Circuit's *Puritan Insurance Co.* analysis is especially apt:

> With the increasing frequency of large deductibles and various forms of self-insurance, excess carriers must scrutinize the actions of the insured as well as those of the primary insurer for evidence of bad faith. This record, however, discloses nothing to suggest that [the insured] Northwest was acting in bad faith toward its excess insurer, Puritan. In any event, we need not address the possibility of

Re: National Union's "Direct Duty" Tort Theory

Apart from the equitable subrogation theory, National Union argues that Columbia owes it a duty *directly*: "The important concept is that each underlying insurer owes duties to those insurers whose limits will be reached upon exhaustion of theirs." Plaintiff's Brief in Support of its Motion for Summary Judgment,and in Response to Columbia Casualty's Motion for Summary Judgment, p. 14. Specifically, under the direct duty theory, the lower layer insurer owes the upper layer insurer a direct duty of good faith and fair dealing.

Texas has not recognized the direct duty theory posited by National Union. *See e.g., International Insurance Co. v. Dresser Industries,* 841 S.W.2d 437 (Tex. App. — Dallas 1992). And it is not at all clear that it will.

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footnote 9 continued

> such liability because it was not alleged here. [ ]
>
> The duty to settle was developed to protect the insured's interest in avoiding excess liability. When an insured — fully aware of such exposure — decides that his interests are better served by going to trial, a finding of bad faith on the part of the carrier is highly unlikely. On the record of this case, we hold that Puritan, as subrogee of Northwest, cannot recover.

Puritan Insurance Co. v. Canadian Universal Insurance Co., 775 F.2d 76, 81 (3rd Cir. 1985) (citing Edward C. Gallager and Michael D. German, *Resolution of Settlement Conflicts Among Insured, Primary Insurers and Excess Insurers,* 61 NEB. L. REV. 285 (1982)). *See also e.g., Royal Transit v. Central Surety & Insurance Corp.,* 168 F.2d 345, 347 (7th Cir.), *cert. denied,* 335 U.S. 844 (1948) ("It is difficult to discern how the insurer in any case could be guilty of bad faith toward its insured for refusing to make a settlement when such refusal was agreed to or joined into by the insured.") (construing Wisconsin law); *Sanders v. Standard Mutual Insurance Co.,* 492 N.E.2d 917 (Ill. App. 1986) (holding that the insured's assignee was estopped from asserting bad faith for insurer's failure to settle underlying suit within policy limits where insured's own actions induced insurer to try the case).

Cf. American Centennial Insurance Co. v. Canal Insurance Co., 843 S.W.2d 480, 483-485 (Tex. 1992) (Doggett, J.) ("Only a few jurisdictions have permitted a direct action, rather than limiting the excess carrier to an equitable subrogation claim. * * * Because none of the [defenses assertable against an insured] is present in the case before us, . . . and the excess insurers appear to have an adequate remedy using equitable subrogation, we decline at this time to permit a direct action."), *with id.* at 485-486 (Hecht, J., concurring, joined by Phillips, C.J. and Gonzalez, Cook and Cornyn, JJ.) (in general, taking a much more conservative approach to the Texas Supreme Court's allowance for excess carriers to utilize the equitable subrogation doctrine). But even assuming National Union could avail itself of the direct duty doctrine, its claim against Columbia must fail as a matter of law. *See Certain Underwriters v. Fidelity and Casualty Insurance Co.*, 789 F. Supp. 927, 933-934 (N.D. Ill. 1992) (holding that even assuming the lower layer insurance carrier generally owes a direct duty to the upper layer insurer — to attempt to settle an action against the mutual insured within the lower level insurer's policy limits — a lower level carrier lacking the *authority* to settle the underlying case could not have breached a direct duty to an upper layer insurance carrier by not *attempting* to settle (at least not in light of the fact that it was uncontroverted that the insured was not interested in settling the underlying case).

III. Conclusion

The Court cannot *write* a contractual duty into existence on behalf of National Union, or find a tort duty on the part of Columbia to associate itself with Ariens' hand-

ling of the *Hines* litigation — to the potential detriment of the insured, no less — just to "protect" Top Layer Excess Carrier National Union from having to pay for the claims it contractually obligated itself to pay. If the ability to limit its exposure was so important to National Union, It might have contracted with Ariens for the same sort of liability capping provision Lower Layer Excess Carrier Columbia secured.

Very simple logic suggests that National Union secured a substantial premium from Ariens in order to offset the probability calculation of being exposed to liability beyond the primary/self-insured and lower level excess layers. In return for the premium received from Ariens, National Union accepted the risk of insuring against the potential that Ariens might be exposed to a liability beyond Ariens' primary/self-insured retention its and Columbia's lower level excess layers. In short, the contribution it made to the *Hines* settlement is exactly the risk National Union contracted to insure. And this Court will not secure for National Union a "remedy" for the bargain National Union made with Ariens — no matter how unpleasant National Union now regards that bargain to be. In addition to the fact that the duty National Union argues Columbia owed it is not a part of any contract entered into by Ariens, Columbia or National Union, this duty is not imposed by tort law (directly or derivatively).

Finally, the parties have not discussed Plaintiff's Texas Insurance Code and Texas Deceptive Trade Practices Act claims in their summary judgment papers, but Plaintiff has argued Texas law governs this matter *because these Texas statutory claims were raised in the Complaint.*

These claims are deemed necessarily adjudicated against Plaintiff — in light of the Court's above, contract and tort-specific analyses.[10]

Accordingly, it is hereby **ORDERED, ADJUDGED AND DECREED** that: (1) Columbia's motion for summary judgment is **GRANTED**; (2) National Union's motion for summary judgment is **DENIED**; and (3) Plaintiff's Texas statutory claims are **NECESSARILY ADJUDICATED UNDER THE ANALYSIS IN THIS *MEMORANDUM OPINION AND ORDER.***

So Ordered.

Signed This the 16th Day of July, 1993.

/s/ Robert M. Parker

HONORABLE ROBERT M. PARKER
CHIEF UNITED STATES DISTRICT COURT JUDGE
EASTERN DISTRICT OF TEXAS

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[10] *See American Centennial Insurance Co. v. Canal Insurance Co.*, 843 S.W.2d 480, 485-486 (Tex. 1992) (Hecht, J. concurring, joined by Phillips, C.J., and Gonzalez, Cook and Cornyn, JJ.) (emphasis added):

> The excess carriers in this case assert claims against the primary carrier based upon negligence, gross negligence, breach of a duty of good faith and fair dealing, and violations of the Texas Deceptive Trade Practices — Consumer Protection Act, TEX. BUS. & COM. CODE §§ 17.41-.63, and article 21.21 of the Texas Insurance Code. Although the Court does not expressly consider which of these theories is available to the excess carriers by subrogation, *I assume* from its reliance on the *Stowers* and *Ranger County* cases, and would so hold, that the *excess carriers' only cause of action is for negligence.*

APPENDIX C

Denial of Motion for Rehearing
pursuant to S.Ct. Rule 14.1(k)(iii)

IN THE UNITED STATES COURT OF APPEALS

FOR THE FIFTH CIRCUIT

NO. 93-5344

RECEIVED
SEP 6 1994

NATIONAL UNION FIRE INSURANCE CO.
OF PITTSBURGH, PENNSYLVANIA,
Plaintiff-Appellant,

versus

CNA INSURANCE COMPANIES and
COLUMBIA CASUALTY COMPANY,
Defendants-Appellees.

FILED
SEP 6 1994

Appeal from the United States District Court for the
Eastern District of Texas

ON PETITION FOR REHEARING

(SEPTEMBER 6, 1994)

Before GARWOOD, EMILIO M. GARZA, Circuit Judges and HEAD*.

PER CURIAM:

IT IS ORDERED that the petition for rehearing filed in the above case is (are) *denied.*

ENTERED FOR THE COURT:

/s/ Emilio M. Garza

United States Circuit Judge

CLERKS NOTE:

SIX FRAP AND LOCAL RULES 41 FOR STAY OF THE MANDATE.

* Judge for the Southern District of Texas, sitting by designation.

APPENDIX D

Statutes Involved in the Case

TEX. INS. CODE ANN. art. 1.14-1. Unauthorized Insurance

Insurance Business Defined

Sec. 2.(a) Any of the following acts in this state effected by mail or otherwise is defined to be doing an insurance business in this state. The venue of an act committed by mail is at the point where the matter transmitted by mail is delivered and takes effect. Unless otherwise indicated, the term insurer as used in this Article includes all corporations, associations, partnerships and individuals engaged as principals in the business of insurance and also includes interinsurance exchanges, mutual benefit societies, and insurance exchanges and syndicates as defined by rules promulgated by the State Board of Insurance.

1. The making of or proposing to make, as an insurer, an insurance contract.

2. The making of or proposing to make, as guarantor or surety, any contract of guaranty or suretyship as a vocation and not merely incidental to any other legitimate business or activity of the guarantor or surety.

3. The taking or receiving of any application for insurance.

4. The receiving or collection of any premium, commission, membership fees, assessments, dues or other consideration for any insurance or any part thereof.

5. The issuance or delivery of contracts of insurance to residents of this state or to persons authorized to do business in this state.

6. Directly or indirectly acting as an agent for or otherwise representing or aiding on behalf of another any person or insurer in the solicitation, negotiation, procurement or effectuation of insurance or renewals thereof or in the dissemination of information as to coverage or rates, or forwarding of applications, or delivery of policies or contracts, or inspection of risks, a fixing of rates or investigation or adjustment of claims or losses or in the transaction of matters subsequent to effectuation of the contract and arising out of it, or in any other manner representing or assisting a person or insurer in the transaction of insurance with respect to subjects of insurance resident, located or to be performed in this state. The provisions of this subdivision shall not operate to prohibit full-time salaried employees of a corporate insured from acting in the capacity of an insurance manager or buyer in placing insurance in behalf of such employer, its parent or affiliated companies.

7. Contracting to provide indemnification or expense reimbursement in this state to persons domiciled in this state or for risks located in this state, whether as an insurer, agent, administrator, trust, funding mechanism, or by any other method, for any type of medical expenses including, but not limited to surgical, chiropractic, physical therapy, speech pathology, audiology, professional mental health, dental, hospital, or optometric expenses, whether this coverage is by direct payment, reimbursement, or otherwise. This provision shall not apply to:

(i) any program otherwise authorized by law that is established by any political subdivision of this state or under the provisions of The Interlocal Cooperation Act (Article 4413(32c), Vernon's Texas Civil Statutes) or by a state agency; or

(ii) a multiple employer welfare arrangement which is fully insured as defined in 29 U.S.C.A. Section 1144(b)(6) except that the Commissioner may apply any laws that

regulate the business of insurance in this state to the extent that such laws provide (1) standards requiring the maintenance of specified levels of contributions, which any such plan, or any trust established under such a plan, must meet in order to be considered under such law able to pay benefits in full when due, and (2) provisions to enforce such standards.

8. The doing of any kind of insurance business specifically recognized as constituting the doing of an insurance business within the meaning of the statutes relating to insurance.

9. The doing or proposing to do any insurance business in substance equivalent to any of the foregoing in a manner designed to evade the provisions of the statutes.

10. Any other transactions of business in this state by an insurer.

11. With respect to policies authorized under Article 3.74 of this code, the use, creation, publication, mailing, or dissemination of an advertisement relating to any of the acts defined in this subsection to be doing an insurance business unless:

(i) that advertisement is used, created, published, mailed, or disseminated on behalf of a person or insurer authorized under this title to engage in the business of insurance in this state, who has actual knowledge of the content of the advertisement and has authorized the advertisement to be used, created, published, mailed, or disseminated on that person's or insurer's behalf; and

(ii) the person or insurer on whose behalf the advertisement is used, created, published, mailed, or disseminated is, in that advertisement, clearly identified by name as the sponsor of the advertisement.

(b) The provisions of this section do not apply to:

1. The lawful transaction of surplus lines insurance pursuant to Article 1.14-2.

2. The lawful transaction of reinsurance by insurers.

3. Transactions in this state involving a policy

lawfully solicited, written, and delivered outside of this state covering only subjects of insurance not resident, located, or expressly to be performed in this state at the time of issuance, and which transactions are subsequent to the issuance of such policy.

4. Transactions involving contracts of insurance independently procured through negotiations occurring entirely outside of this state which are reported and on which premium tax is paid in accordance with this Article.

5. Transactions in this state involving group life, health or accidental insurance (other than credit insurance) and group annuities where the master policy of such groups was lawfully issued and delivered in a state in which the company was authorized to do an insurance business and such transactions are authorized by other statutes of this state.

6. Lawful transactions by servicing companies of the Texas workers' compensation employers' rejected risk fund pursuant to Section 4.08, Article 5.76-2.

7. Management and accounting activities in this state on behalf of a non-admitted captive insurance company that insures solely directors' and officers' liability insurance for the directors and officers of its parent and affiliated companies and/or the risks of its parent and affiliated companies. This provision does not exempt any insured or insurer from the payment of any applicable tax on premiums or any other applicable provision in this code.

(c) The State Board of Insurance shall promulgate rules defining insurance exchanges and syndicates covered by Subsection (a) of this section.

TEX. INS. CODE ANN. art. 21.21. Unfair Competition and Unfair Practices

Declaration of Purpose

Sec. 1. (a) The purpose of this Act is to regulate trade practices in the business of insurance by defining, or pro-

viding for the determination of, all such practices in this state which constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined.

(b) This Article shall be liberally construed and applied to promote its underlying purposes as set forth in this section.

Definitions

Sec. 2. When used in this Article:

(a) "Person" shall mean any individual, corporation, association, partnership, reciprocal exchange, interinsurer, Lloyds insurer, fraternal benefit society, and any other legal entity engaged in the business of insurance, including agents, brokers, adjusters and life insurance counselors.

(b) "Board" shall mean the State Board of Insurance.

(c) "Knowingly" means actual awareness of the falsity, unfairness, or deception of the act or practice made the basis for a claim for damages under Section 16 of this Article. "Actual awareness" may be inferred where objective manifestations indicate that a person acted with actual awareness.

Unfair methods of competition or unfair and deceptive acts or practices prohibited

Sec.3. No person shall engage in this state in any trade practice which is defined in this Act as, or determined pursuant to this Act to be, an unfair method of competition or an unfair or deceptive act or practice in the business of insurance.

Unfair Methods of Competition and Unfair or Deceptive Acts or Practices Defined

Sec. 4. The following are hereby defined as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance:

(1) Misrepresentations and False Advertising of Policy Contracts. Making, issuing, circulating, or causing to be made, issued or circulated, any estimate, illustration, circular or statement misrepresenting the terms of any policy issued or to be issued or the benefits or advantages promised thereby or the dividends or share of the surplus to be received thereon, or making any false or misleading statements as to the dividends or share of surplus previously paid on similar policies, or making any misleading representation or any misrepresentation as to the financial condition of any insurer, or as to the legal reserve system upon which any life insurer operates, or using any name or title of any policy or class of policies misrepresenting the true nature thereof, or making any misrepresentation to any policyholder insured in any company for the purpose of inducing or tending to induce such policyholder to lapse, forfeit, or surrender his insurance;

(2) False Information and Advertising Generally. Making, publishing, disseminating, circulating or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio or television station, or in any other way, an advertisement, announcement or statement containing any assertion, representation or statement with respect to the business of insurance or with respect to any person in the conduct of his insurance business, which is untrue, deceptive or misleading;

(3) Defamation. Making, publishing, disseminating,

or circulating, directly or indirectly, or aiding, abetting or encouraging the making, publishing, disseminating or circulating of any oral or written statement or any pamphlet, circular, article or literature which is false, or maliciously critical of or derogatory to the financial condition of any insurer, and which is calculated to injure any person engaged in the business of insurance;

(4) Boycott, Coercion and Intimidation. Entering into any agreement to commmit, or by any concerted action committing, any act of boycott, coercion or intimidation resulting in or tending to result in unreasonable restraint of, or monopoly in, the business of insurance;

(5) False Financial Statements. (a) Filing with any supervisory or other public official, or making, publishing, disseminating, circulating or delivering to any person, or placing before the public, or causing directly or indirectly, to be made, published, disseminated, circulated, delivered to any person, or placed before the public, any false statement of financial condition of an insurer with intent to deceive;

(b) Making any false entry in any book, report or statement of any insurer with intent to deceive any agent or examiner lawfully appointed to examine into its condition or into any of its affairs, or any public official to whom such insurer is required by law to report, or who has authority by law to examine into its condition or into any of its affairs, or, with like intent, wilfully omitting to make a true entry of any material fact pertaining to the business of such insurer in any book, report or statement of such insurer;

(6) Stock Operations and Advisory Board Contracts. Issuing or delivering or permitting agents, officers or employees to issue or deliver, company stock or other

capital stock, or benefit certificates or shares in any corporation, or securities or any special or advisory board contracts or other contracts of any kind promising returns and profits as an inducement to insurance. Provided, however, that nothing in this subsection shall be construed as prohibiting the issuing or delivery of participating insurance policies otherwise authorized by law.

(7) Unfair Discrimination. (a) Making or permitting any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any contract of life insurance or of life annuity or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of such contract;

(b) Making or permitting any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract of accident or health insurance or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever;

(c) Making or permitting any unfair discrimination between individuals or risks of the same class and of essentially the same hazards by refusing to renew, cancelling or limiting the amount of coverage on a policy of insurance covered by Subchapter C, Chapter 5, of this code[1] because of the geographic location of the risk unless:

(1) the refusal, cancellation or limitation is for a business purpose that is not a mere pretext for unfair discrimination; or

(2) the refusal, cancellation or limitation is required by law or regulatory mandate.

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[1] Article 5.13 et seq.

(8) Rebates. (a) Except as otherwise expressly provided by law, knowingly permitting or offering to make or making any contract of life insurance, life annunity or accident and health insurance, or agreement as to such contract other than as plainly expressed in the contract issued thereon, or paying or allowing, or giving or offering to pay, allow, or give, directly or indirectly, as inducement to such insurance, or annuity, any rebate of premiums payable on the contract, or any special favor or advantage in the dividends or other benefits thereon, or any valuable consideration or inducement whatever not specified in the contract; or giving, or selling, or purchasing or offering to give, sell, or purchase as inducement to such insurance or annuity or in connection therewith, any stocks, bonds, or other securities of any insurance company or other corporation, association, or partnership, or any dividends or profits accrued thereon, or anything of value whatsoever not specified in the contract;

(b) Nothing in clause 7 or paragraph (a) of clause 8 of this subsection shall be construed as including within the definition of discrimination or rebates any of the following practices:

(i) in the case of any contract of life insurance or life annuity, paying bonuses to policyholders or otherwise abating their premiums in whole or in part out of surplus accumulated from non-participating insurance, provided that any such bonuses or abatement of premiums shall be fair and equitable to policyholders and for the best interests of the company and its policyholders;

(ii) in the case of life insurance policies issued on the industrial debit plan, making allowance to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer in an

amount which fairly represents the saving in collection expenses;

(iii) readjustment of the rate of premium for a group insurance policy based on the loss or expense experience thereunder, at the end of the first or any subsequent policy year of insurance thereunder, which may be made retroactive only for such policy year.

(9) Deceptive Name, Word, Symbol, Device, or Slogan. Using, displaying, publishing, circulating, distributing, or causing to be used, displayed, published, circulated, or distributed in any letter, pamphlet, circular, contract, policy, evidence of coverage, article, poster, or other document, literature, or public media of:

(a) a name as the corporate or business name of a person or entity engaged in an insurance or insurance related business in this state that is the same as, or deceptively similar to, the name adopted and used by an insurance entity, health maintenance organization, third party administrator, or group hospital service company authorized to do business under the laws of this state; or

(b) a word, symbol, device, slogan, or any combination of these items, whether registered or not registered, that is the same as deceptively similar to one adopted and used by an insurance entity, health maintenance organization, third party administrator, or group hospital service company to distinguish such entities, products, or service from other entities, and includes the title, designation, character names, and distinctive features of broadcast or other advertising. Where two persons or entities are using a name, word, symbol, device, slogan, or any combination of these items that are the same or deceptively similar and are likely to cause confusion or a mistake, the user who can demonstrate the first continuous actual use of such name,

word, symbol, device, slogan, or combination of these items shall not have committed an unfair method of competition or deceptive act or practice.

....

Relief Available to Injured Parties

Sec. 16. (a) Any person who has sustained actual damages as a result of another's engaging in an act or practice declared in Section 4 of this Article or in rules or regulations lawfully adopted by the Board under this Article to be unfair methods of competition or unfair or deceptive acts or practices in the business of insurance or in any practice defined by Section 17.46 of the Business & Commerce Code, as amended, as an unlawful deceptive trade practice may maintain an action against the person or persons engaging in such acts or practices.

(b) In a suit filed under this section, any plaintiff who prevails may obtain:

(1) the amount of actual damages plus court costs and reasonable and necessary attorneys' fees. If the trier of fact finds that the defendant knowingly committed the acts complained of, the court shall award, in addition, two times the amount of actual damages; or

(2) an order enjoining such acts or failure to act; or

(3) any other relief which the court deems proper.

(c) On a finding by the court that an action under this section was groundless and brought in bad faith or brought for the purpose of harassment, the court shall award to the defendant reasonable and necessary attorneys' fees and court costs.

(d) All actions under this Article must be commenced within two years after the date on which the unfair method

of competition or unfair or deceptive act or practice occurred or within two years after the person bringing the action discovered or, in the exercise of reasonable diligence, should have discovered the occurrence of the unfair method of competition or unfair or deceptive act or practice. The period of limitation provided in this section may be extended for a period of 180 days if the person bringing the action proves that the failure to timely commence the action was caused by the defendant's engaging in conduct solely calculated to induce the plaintiff to refrain from or postpone the commencement of the action.

(e) As a prerequisite to filing a suit seeking damages under this section against any person, the person seeking damages shall give written notice to the other person at least 30 days before filing suit. The notice must advise the person of the specific complaint and the amount of actual damages and expenses, including any attorneys' fees reasonably incurred in asserting the claim against the defendant.

(f) If giving 30 days' written notice is impracticable because the suit must be filed in order to prevent the expiration of the statute of limitations or because the claim is asserted as a counterclaim, the notice provided for in Subsection (e) of this section is not required, and the tender of a written offer of settlement provided for by Subsection (g) of this section may be made not later than the 30th day after the date of filing of the suit or counterclaim.

(g) A person who receives the written notice provided by Subsection (e) of this section may tender, not later than the 30th day after the date of receipt of the notice, to the person seeking damages, a written offer of settlement, including an agreement to reimburse the person for any at-

torneys' fees reasonably incurred in asserting the claim to the date of the written notice. A person who does not receive a written notice because of the suit or counterclaim is filed as provided for by Subsection (f) of this section may tender, not later than the 30th day after the date of filing of the suit or counterclaim, a written offer of settlement, including an agreement to reimburse the person for any attorneys' fees reasonably incurred in asserting the claim to the date the suit or counterclaim was filed. An offer of settlement is rejected if it is not accepted on or before the 30th day after the date of receipt by the person seeking damages.

(h) A rejected settlement offer made in complaince with Subsection (g) of this section may be filed with the court with an affidavit certifying its rejection. If the court finds that the amount tendered in the settlement offer is the same or substantially the same as the actual damages found by the trier of fact, the plaintiff may not recover an amount that exceeds the lesser of:

(1) the amount tendered in the settlement offer; or

(2) the amount of actual damages found by the trier of fact.

(i) The tender of an offer of settlement is not an admission of engaging in an unlawful act or practice or of liability under this Article. Evidence of a settlement offer may be introduced only to determine the reasonableness of the settlement offer as provided for by Subsection (h) of this section.

TEX. BUS. & COM. CODE ANN. § 17.46 (Vernon 1987).
Deceptive Trade Practices Unlawful

(a) False, misleading, or deceptive acts or practices in

the conduct of any trade or commerce are hereby declared unlawful and are subject to action by the consumer protection division under Sections 17.47, 17.58, 17.60, and 17.61 of this code.

(b) Except as provided in Subsection (d) of this section, the term "false, misleading, or deceptive acts or practices" includes, but is not limited to, the following acts:

(1) passing off goods or service as those of another;

(2) causing confusion or misunderstanding as to the source, sponsorship, approval, or certification of goods or services;

(3) causing confusion or misunderstanding as to affiliation, connection, or association with, or certification by, another;

(4) using deceptive representations or designations of geographic origin in connection with goods or services;

(5) representing that goods or services have sponsorship, approval, characteristics, ingredients, uses, benefits, or quantities which they do not have or that a person has a sponsorship, approval, status, affiliation, or connection which he does not;

(6) representing that goods are original or new if they are deteriorated, reconditioned, reclaimed, used, or secondhand;

(7) representing that goods or services are of a particular standard, quality, or grade, or that goods are of a particular style or model, if they are of another;

(8) disparaging the goods, services, or business of another by false or misleading representation of facts;

(9) advertising goods or services with intent not to sell them as advertised;

(10) advertising goods or services with intent not to supply a reasonable expectable public demand, unless

the advertisements disclosed a limitation of quantity;

(11) making false or misleading statements of fact concerning the reasons for, existence of, or amount of price reductions;

(12) representing that an agreement confers or involves rights, remedies, or obligations which it does not have or involve, or which are prohibited by law;

(13) knowingly making false or misleading statements of fact concerning the need for parts, replacement, or repair service;

(14) misrepresenting the authority of a salesman, representative or agent to negotiate the final terms of a consumer transaction;

(15) basing a charge for the repair of any item in whole or in part on a guaranty or warranty instead of on the value of the actual repairs made or work to be performed on the item without stating separately the charges for the work and the charge for the warranty or guaranty, if any;

(16) disconnecting, turning back, or resetting the odometer of any motor vehicle so as to reduce the number of miles indicated on the odometer gauge;

(17) advertising of any sale by fraudulently representing that a person is going out of business;

(18) using or employing a chain referral sales plan in connection with the sale or offer to sell of goods, merchandise, or anything of value, which uses the sales technique, plan, arrangement, or agreement in which the buyer or prospective buyer is offered the opportunity to purchase merchandise or goods and in connection with the purchase receives the seller's promise or representation that the buyer shall have the right to receive compensation or consideration in any form for furnishing to the seller the

names of other prospective buyers if receipt of the compensation or consideration is contingent upon the occurrence of an event subsequent to the time the buyer purchases the merchandise or goods;

(19) representing that a guarantee or warranty confers or involves rights or remedies which it does not have or involve, provided, however, that nothing in this subchapter shall be construed to expand the implied warranty of merchantability as defined in Sections 2.314 through 2.318 and Sections 2A.212 through 2A.216 of the Business & Commerce Code to involve obligations in excess of those which are appropriate to the goods;

(20) selling or offering to sell, either directly or associated with the sale of goods or services, a right of participation in a multi-level distributorship. As used herein, "multi-level distributorship" means a sales plan for the distribution of goods or services in which promises of rebate or payment are made to individuals, conditioned upon those individuals recommending or securing additional individuals to assume, positions in the sales operation, and where the rebate or payment is not exclusively conditioned on or in relation to proceeds from the retail sales of goods;

(21) representing that work or services have been performed on, or parts replaced in, goods when the work or services were not performed or the parts replaced;

(22) filing suit founded upon a written contractual obligation of and signed by the defendant to pay money arising out of or based on a consumer transaction for goods, services, loans, or extensions of credit intended primarily for personal, family, household, or agricultural use in any county other than in the county in which the defendant resides at the time of the commencement of the

action or in the county in which the defendant in fact signed the contract; provided, however, that a violation of this subsection shall not occur where it is shown by the person filing such suit he neither knew or had reason to know that the county in which such suit was filed was neither the county in which the defendant resides at the commencement of the suit nor the county in which the defendant in fact signed the contract;

(23) the failure to disclose information concerning goods or services which was known at the time of the transaction if such failure to disclose such information was intended to induce the consumer into a transaction into which the consumer would not have entered had the information been disclosed; or

(24) using the term "corporation," "incorporated," or an abbreviation of either of those terms in the name of a business entity that is not incorporated under the laws of this state or another jurisdiction.

APPENDIX E

Excerpts from Plaintiff's Motion for Summary Judgment (Tr. 245-260).

EVIDENCE INDICATING CNA'S ACTUAL CONTROL OVER ALL ASPECTS OF THE CLAIM AGAINST ARIENS, AND ITS NEGLIGENCE IN THE EXERCISE OF THAT CONTROL.

1. TESTIMONY OF IRV CURRY, CORPORATE COUNSEL FOR ARIENS

In the past, only one other case (Evans) had even used up the self insured retention of CNA's policy (Curry Depo. pg. 16 - 17). The servicing contractor, Martin Boyer Co., knew how to set reserves and Curry didn't. CNA had not even asked Ariens when it settled other small cases in the past (depo. pg. 28). Mr. Curry was relying on trial counsel and Mr. Berterman with CNA to advise as to a proper settlement figure. (Curry depo. pg. 19 - 21). Mike Ariens who owned the company was relying on Curry, and he on CNA to be told what to do about settling and appealing claims. (Curry depo. pg. 58 - 59; pg. 79 - 80). Mike Ariens did not manifest reluctance to settle this case (Curry depo. pg. 70). Mike Ariens really wasn't equipped to make the decision as to settlement (Px. 91a, depo. pg. 76 - 79). No one ever came to him before trial with a specific figure and asked permission to pay it. (Curry Depo. pg. 21 - 23). He needed a specific amount to go to Mike Ariens with (Curry depo. pg. 19 - 21). The only Ariens person at trial was Mr. Johnson, who was an engineer and not an executive, and had no authority to decide whether to settle or not (Curry

depo. pg. 63). After trial, there may have been other numbers CNA asked for permission to settle for, and if they asked for permission, it was given each time, but then later, CNA said permission wasn't enough, Ariens had to demand settlement (Curry depo. pg. 60 -61). Ariens never refused consent and was not consulted about what to settle for, and later, CNA claimed that Ariens not only had to consent, it had to demand settlement. (Curry depo. pg. 22 - 24).

As to what information CNA gave Ariens in this case, Curry, who would have been the one to get the information says that he was never told about Jackie Fountain's notes that they had only a thirty percent chance of winning, jury verdict in the $2 - 3 million range, we will lose the case and defense counsel agrees, etc., (Nov. 15, 1986 hand note in Px. 1), doesn't know if he was told CNA evaluated the case at $1.2 mil as of June '87 (Px. 36), (Curry depo. pg. 39 -40), doesn't remember being told about the $750,000 offer in Weitinger's letter (Curry depo. pg. 46 - 47), was not made aware of offers during trial (Curry depo. pg. 48), and never had any conversations with Fountain or anyone else from CNA during trial (Curry depo. pg. 74 -76).

2. TESTIMONY OF WILLIAM KUNZ, ASST. V.P. OF CNA/COLUMBIA

Mr. Kunz was Mr. Berterman's supervisor, and approved his evaluations of claims against the insureds for large amounts of money. (Kunz depo. pg. 42. 1. 2 -24). The first suggestion of a reserve for the file was from Martin Boyer Co., in 1985. (Kunz depo. pg. 32, 1. 10 - pg. 40, 1. 10). The first 90 day evaluation of the case was done on July 8,

1986 by Tom Cardoza with CNA in Houston, who evaluated the claim and suggested a reserve (CNA calls them "case estimates" [Kunz depo. pg. 37, 1. 2 - pg. 38, 1. 4]) of $750,000.00 (Kunz depo. pg. 38, L. 14 - pg. 40, 1. 10).

Mr. Kunz was not aware of Mr. Berterman doing anything to evaluate the case before June, 1987. (Kunz depo. pg. 48, 1. 18 - pg. 49, 1. 9). As of June 25, 1987, Berterman suggested raising the reserve on the file to $1,100,000.00, and he approved the increase. (Kunz depo. pg. 24, 1.3 - pg. 27, 1. 6; pg. 49, 1. 10 - pg. 53, 1. 19). He certainly would have felt that it should have been determined whether the $750,000.00 offer was firm when Weitinger passed it on. (Kunz depo. pg. 64, 1. 1 -14).

3. DON WEITINGER'S TESTIMONY. Mr. Weitinger represented the parents of the minor plaintiff who were Defendants in the case. They had been made defendants in the case by Ariens. Mr. Weitinger's entire deposition shows what kind of conduct CNA was guilty of in this case.

He saw "no effort" to settle the case (Weitinger depo. pg. 51 - 52). He saw no good faith effort on CNA's part to settle (Weitinger depo. pg. 62). He evaluated the case as a very dangerous one. (Weitinger depo. pg. 15, 1. 8 - pg. 17, 1. 12). The claimant's cause of action against Ariens was a strict liability one. (Weitinger depo. pg. 19, 1. 11 - 19). Recognizing from the beginning how dangerous the case was, Weitinger began to ask for settlement authority from the very beginning because he did not want his client to be the target defendant in Trinity County. (Weitinger depo. pg. 21, 1. 20 - pg. 26, 1. 6). Weitinger

had numerous discussions with CNA as to settlement, and CNA failed to use any reasonable care as to negotiating the claim. (Weitinger depo. pg. 26, 1. 7 - pg. 39, 1. 20). Weitinger met with Ernie Cannon, the claimant's attorney in Cannon's office shortly before trial. Cannon was sick, wanted to settle the case, and would accept $750,000.00 to settle with Ariens. Weitinger called CNA and passed that on to them from Cannon's office. (Weitinger depo. pg. 32, 1. 3 - pg. 37, 1. 5).

Ariens just cut blacks off the jury. (Weitinger depo. pg. 41, 1. 2 - 8). The trial went very badly for Ariens - Ariens was "getting killed," and the jury was not appreciating the tactics of Ariens' counsel. (Weitinger depo. pg. 39, 1. 20 - pg. 40, 1. 11). Weitinger called his partner, Jack Tucker, to try to get him to get CNA to get someone at the trial with authority to settle the case, but instead, Jackie Fountain showed up (Weitinger depo. pg. 41, 1. 9 - pg. 43, 1. 15). She did not have enough authority to get anything done. (Weitinger depo. pg. 57, 1. 13 - pg. 60, 1. 1). Ernie Cannon had been raised in Trinity County, and was very effective there. (Weitinger depo. pg. 44, 1. 24 - pg. 45, 1. 25). Weitinger knows Cannon well, has tried and settled a lot of cases against him, and knows he would have settled if a reasonable offer had been made to him. (Weitinger depo. pg. 46, 1. 1 - pg. 47, 1. 20). Weitinger recognizes the duty of an insurer to initiate negotiations (Weitinger depo. pg. 47, 1. 21 - pg. 48, 1. 24), and *saw no effort on CNA'S part to settle this case.* (Weitinger depo. pg. 47, 1. 21 - Pg. 48, 1. 24; pg. 51, 1. 23 - pg. 52, 1. 1). Weitinger did not believe CNA acted in good faith on Ariens' behalf as to settlement. (Weitinger depo. pg. 62, 1. 14 - 23). Weitinger got no help from CNA as to settlement of the case. (Weitinger depo. pg.

59, l. 6 - pg. 60, l. 14).

4. ROGER MCGRATH'S TESTIMONY. Mr. McGrath is an executive with Ariens Co., the insured. He is the individual CNA got to give an affidavit indicating that Ariens did not think CNA had violated any of its duties to Ariens.

Before the trial, he only had a "conversational knowledge of the file," but knew about the severity of the injuries. (McGrath depo. pg. 9). He had no contact with anyone from CNA before trial (McGrath depo. pg. 9 - 10). He had no contact with Myers before trial (McGrath depo. pg. 10). No offers were passed on to him before trial (McGrath depo. pg. 10), and he had no meetings with CNA after trial (McGrath depo. pg. 10 - 11). At no time did he hear of any particular sum that CNA wanted to pay that was refused (McGrath depo. pg. 11 - 12; pg. 18 - 19). He was totally uninformed as of the trial or even after as to what either CNA or Myers thought the case was worth (McGrath depo. pg. 13 - 14). He was advised after trial that the chances of appeal were bad (McGrath depo. pg. 14 - 15). Ariens wasn't informed of the $1.2 million offer or the $750,000 offer, or any other offer except the original $6 million offer (McGrath depo. pg. 19 - 20). He heard those numbers bandied about after trial, but not as offers (McGrath depo. pg. 26). Ariens never had a specifc offer of any amount made to it that they could accept or reject (McGrath depo. pg. 26 -27).

5. OTHER EVIDENCE AS TO CNA'S CONDUCT

The Home Office of CNA set all the reserves on the

case (Fountain depo. pg. 16 - 20). Jackie Fountain indicated CNA exercised control and wanted Mike Myers, the attorney defending Ariens, to develop the defense like CNA wanted (Fountain deposition, pg. 57 - 58). CNA told Jackie Fountain to tell Myers what to offer (Fountain deposition, pg. 75 - 76). For the first time, long after the trial, CNA began to attempt to change its position to require the insured not only to approve a settlement, but also to demand a settlement and do the negotiations itself. (Ltr. 11-23-88, Px. 96, 98 and 99. Jack Gerstein to Irv. Curry, cc to Mike Myers).

Note: For the first time, CNA claims that the insured has to actually negotiate the settlement and pay it, even though CNA has made all those decisions without even the consent of the insured up to this point. It was CNA's money which would be paid, and it does not make common sense for them to allow the insured to negotiate.

Nowhere in the file did CNA ever give Ariens the authority to negotiate. It simply told Myers to pass on offers CNA had decided to make. In fact, Myers testified that he got his authority from CNA, not Ariens (Myers depo. pg. 80). During the trial, he told Mr. Johnson about the offer, but didn't need authority from Ariens - just got it from Jackie Fountain (Myers depo. pg. 80). Mr. Kunz or Gerstein with CNA gave him the authority for the $4.5 million offer after trial (Myers depo. pg. 97 - 98). Mr. Kunz, CNA assistant V.P., recoginzes lack of permission from the insured had nothing to do with the problem, and that the insured never withheld permission to settle at any time (Kunz depo. pg. 76 - 77). He recognizes that they never went to Ariens and asked them for authority to settle the claim for

a specific amount or less (Kunz depo. pg. 86). No CNA employee says they ever asked for any permission for any specific settlement which permission was denied. Bryan Blakeley, a partner of Myers' also verifies that CNA never asked Ariens for permission to settle for a specific amount, and Ariens never withheld any permission to settle for a specific amount (Blakeley depo. pg. 105 - 107). He also said that no one ever claimed that a demand was required from Ariens before CNA had to settle (Blakeley depo. pgs. 107 - 108, 110, 113, 115 - 117).

6. DOCUMENTARY EVIDENCE ALSO CONFIRMS THESE FACTS

The following documents indicate CNA's control over the defense and settlement of this case, and its negligence and violations of Art. 21.21, Ins. Code of Texas:

NOTE: ALL FILE ACTIVITY SHEETS ARE FOUND IN PX. 1, FILED CHRONOLOGICALLY.

1. Ltr. Martin Boyer, an independent adjusting firm, to David Berterman, home office claim specialist at CNA, dated May 5, '86, Px 6. Shows everyone recognizes CNA is setting reserve. Px. 8, also.

2. Ltr. David Berterman at home office of CNA to Borchardt at Martin Boyer Co., independent adjuster in the case, dated 5-15-86. This letter tells Borchardt to tell defense counsel to cooperate with CNA's adjuster. Px. 9.

3. *FIRST NOTICE* ltr. David Berterman in home office to Houston office. Px. 10, 5-16-86. Tells Houston office to advise the insured of "our interests," get copy of

Boyer's entire file, tells CNA's Houston office that it cannot do much of anything - issue drafts, spend anything without CNA's home office approval; also, can't initiate any processing document or change anything.

4. *File Activity Sheet* entry June 16, '86. CNA adjuster in Houston says he will inform the insured that he, the CNA adjuster, needs to be involved in any further investigation/discovery.

5. Ltr. Tom Cardoza, CNA Houston adjuster to Bryan Blakeley, attorney defending insured. Px. 11, June 16, '86. Asks for a report as to liability, damages, value of the case. Says they need such a report to "determine our reserve adequacy." This recognizes CNA is setting reserve on the case. Wants to hear from the attorney "in the very near future." This is the kind of letter an insurer writes when it is controlling negotiations.

6. Ltr. Bryan Blakeley, defense counsel to Tom Cardoza, CNA's Houston adjuster. Px. 12, July 2, '86. This report answers some of the questions asked by Cardoza. Defense counsel just sends copies to the insured, "his client." With a couple of exceptions, from now till the trial, Groce, Locke and Hebdon, the attorneys report to CNA, not the insured, the client.

7. Note in *File Activity Sheet* 7-8-86, indicates the kind of statuts report an insurer is accustomed to getting in a case where it is defending.

8. Note in Groce, Locke file 7-22-86, Px. 13a. Bryan Blakeley to Mike Myers, another attorney in the firm, that

he had talked to David Berterman, claim specialist in CNA's home office, who "asked me to tell him all the good things about the file. It was a short conversation." This shows Berterman at home office of CNA is involving himself directly in the case. Also directs attorneys to explore the possibility of a structured settlement. Obviously, the insured wouldn't be in the business of settling on that basis. This shows intention of CNA to pay in the first instance, not indemnify the insured, and to control the method of settlement.

9. Ltr. Mike Myers, attorney to Irv Curry, the attorney in the insured's home town who handles all claims against the insured and acts as the go-between the insured and CNA as to all claims, dated 8-7-86, Px. 14a. Tells the attorney for the insured of a $2.5 million offer and asks for "thoughts" from Curry. All he gets is instruction to ask Berterman, the CNA home office specialist, for authority above the insured's SIR (self insured retention or deductible).

10. *File Activity Sheet* 8-28-86. Local Houston CNA adjuster contacts Groce, Locke and finds out the case has been continued. Says CNA home office wants an evaluation of the case from the local Houston adjuster.

11. *File Activity Sheet* 9-23-86. Local Houston CNA adjuster reviewed file and discussed it with defense counsel. Says "our policy provides for $750,000 on an aggregate basis."

12. *File Activity Sheet. 11-11-86.* Talks about "moving the case to Federal Court." CNA appears to consider

moving the case to Federal Court - this is certainly one of the things an insurer with control of the defense would consider. There is no indication that CNA felt it had to get the insured's permission to do this. Then the local Houston CNA adjuster calls Myers and Blakeley who are defense counsel each day till 11-14-86.

13. *File Activity Sheet* 11-14-86. Local Houston adjuster talks to Bryan Blakeley, defense counsel, and gets information which is sent to Berterman at the CNA home office the next day, 11-15-86. Shows defense counsel called the CNA adjuster, not the insured, to report on the progress of the case. No report was sent to the insured at this time. Defense counsel reports as to coverage of a co-defendant, and shows CNA knows the other defendant has offered $1 million to settle with the claimant. This says "DA (Defense Attorney) agrees with me we will probably lose this case." Future medical could be over $500,000. Jury Verdict could be in the $2,000,000 - 3,000,000 range. He feels our chances to prevail are not over 30%. Also, 40% -50% of county in which the trial will occur are black. ... "I feel if we can settle this hopefully via a structure for a somewhat reasonable figure, we should consider this option. This is a small East Texas town with the only lawyers in town on the Plaintiff's side. ... However, the Plaintiff is black, and there is a lot of prejudice in East Texas - if we could get a mostly white jury. This is a small child though, and the prejudice may not be so important. Asked defense counsel to approach plaintiff's lawyer as to settlement."

14. Note in the Groce, Locke file from Bryan Blakeley to Mike Myers, Px. 16a. "CNA wants an offer from Plaintiff as soon as possible."

15. Ltr. from Irv Curry, insured's local counsel in home town of factory to Myers, defense counsel and Berterman, the home office specialist at CNA, dated 11-18-86, Px. 17. Insured does agree to contribute its SIR (self insured retention) and says "of course, beyond that, Mr. Berterman must provide any authority." Also tells Myers as to Berterman to "speak to him concerning settlement authority." This is a very clear indication that the insured was looking to CNA to decide when and for how much to settle the case.

16. Ltr. Px. 19, 1-26-87, Jackie Fountain, CNA's Houston adjuster to Groce, Locke, defense counsel requests status report and asks him to try to settle.

17. Ltr. Px. 20, 2-6-87, Bryan Blakeley, defense counsel to Jackie Fountain, CNA Houston adjuster. Just shows a copy to the client. Also, Blakeley indicates he is going to carbon copy CNA's adjuster as to all matters in the case in the future. He (defense counsel) doesn't even do this for his client. Future correspondence does not even show copies to his "client" the insured.

18. CRT (cathode ray tube - type of computer document) dated 3-4-87, Px. 22. Berterman at CNA's home office sends note to Jackie Fountain, CNA's Houston adjuster, telling her that the SIR (self insured retention) is actually only $100,000.

19. Ltr. 3-31-87, Px. 24. Jackie Fountain, local Houston adjuster to Mike Myers, defense counsel. Requests a report from him as to status and as to settlement demand. No carbon copy to the insured, and never any re-

quest that insured intervene with Myers to report on the case.

20. Ltr. 4-6-87 Px. 25, Myers (defense counsel) to Fountain (CNA's Houston adjuster), Curry (insured's local corporate attorney), Johnson (employee of the insured). Informs all that the trial is now set in Nov. '87.

21. Ltr. 4-7-87, Px. 26. Myers (defense counsel) to Fountain (Houston CNA adjuster). This is a reply to a request for a status report. Now it is addressed solely to CNA with just copies to the client. Indicates that he has gotten no authorization from Ariens as to settlement. This ignores Mr. Curry's earlier letter telling him to get all his authority from Berterman. To remind him of this, Mr. Curry writes him and again offers to pay the SIR. See Px. 26a, 4-10-87.

22. CRT (computer generated document) dated 4-13-87, Px. 27, 28. Instructions CNA wants forwarded to defense counsel on how to conduct defense. These are passed on to Myers in Px. 29, 4-21-87. Also, again discusses a structured settlement and asks defense counsel to discuss it with the claimant's attorney. Actually, the desire for a structured settlement has nothing to do with the insured - the insured is not involved in that feature of any possible settlement at all.

23. Ltr. Px. 30, 5-21-87. Defense counsel Mike Myers to White. The part of the CNA letter of May 16, '86 which is attached would indicate Myers was aware of and was following CNA's rules concerning the handling of the case.

24. Ltr. 6-11-87, Px. 33. Jackie Fountain, CNA ad-

juster, to Myers, defense counsel. "You haven't answered my 4-21-87 letter. Please do." No carbon copy to the insured, his client.

25. 6-17-87, Px. 118 A - D. Berterman to Kunz. Explains this and other cases described on "BLUE SHEETS" Exhibits 118 A - D. This is date of case revisions described in those exhibits. Raises reserve to $1,100,000.00 on this claim. (Total $1,200,000.00 on 6 cases, but other 5 total only $100,000.)

26. Ltr. 6-18-87. Px. 35. Mike Myers, defense counsel, to Jackie Fountain, CNA Houston adjuster. He agrees that a structure would be good, "If you deem such appropriate, however, would you prefer that it be done through CNA or some other entity?" This appears to be an example of an attorney trying to accomplish the insurer's instructions. The structured settlement was never the insured's idea. Also, Myers reports on aspects of the defense of the claim. He also says that it appeared to him as a lawyer that a verdict would probably go against Ariens and the company's witnesses did worse than he thought they would, and all the other evidence went about as expected (Myers deposition. pg. 123 - 124).

27. Ltr. 6-22-87, Px. 36. Berterman to F. Waters. SIGNIFICANT CLAIM DEVELOPMENT. Reports increase of case estimate on this case to $900,000 on first layer policy and 300,000 on umbrella. $100,000 is set on other aggregate files of Ariens as to primary, exhausting limits on it.

NOTE: Now, one full year before trial, CNA evaluates the